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The Experience of Menopausal Transition among Amish Women

Desiree R. Batson
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To the Graduate Council:

I am submitting herewith a dissertation written by Desiree R. Batson entitled "The Experience of Menopausal Transition among Amish Women." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Sandra Thomas, Major Professor

We have read this dissertation and recommend its acceptance:

Johnie N. Mozingo, Mitzi Davis, Howard Pollio

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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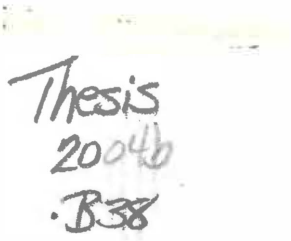
THE EXPERIENCE OF MENOPAUSAL TRANSITION AMONG AMISH WOMEN

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Desiree R. Batson
May 2004



DEDICATION

This dissertation is dedicated to my children, my parents, and the rest of my family, who have always believed in me, encouraged me, and provided me with the strength to achieve my goals.

ACKNOWLEDGEMENTS

I would like to thank Dr. Sandra Thomas for her guidance, support, and the gentle pushing to actually realize the completion of my dissertation. I would like to thank my dissertation committee, Dr. Howard Pollio, Dr. Mitzi Davis, and Dr. Johnie Mozingo for their support and guidance. Also, many thanks to the University of Tennessee phenomenology group who provided me with a greater insight of my phenomenon and the encouragement to complete my dissertation. Finally, I owe a special thanks to the group of women who opened their homes to me and spoke so candidly about the menopausal transition.

ABSTRACT

The purpose of this phenomenological study was to explore the meaning of the menopausal transition in Amish women. Using in-depth interviews, 10 Amish women who were transitioning into menopause were asked to respond to the question, "As you think of your experiences going through the 'change of life,' what specific things stand out for you?"

Three themes emerged: "This is such a natural thing." a descriptor of natural/unnatural; "I don't know if what I have has been normal, but what is normal?" a descriptor of change, the expected and unexpected; and "We finally figured it out." a descriptor of a search for clarification/validation. Each theme was interrelated while being imposed on the background of health and the reproductive body.

As described by the participants, the menopausal transition is viewed as part of the reproductive cycle and is therefore considered part of the natural order of life. The accompanying bodily changes are expected and yet distinctly different for each individual woman. Preventive practices to guard against diseases, such as osteoporosis and cardiac disease, are begun early in life while the women are still in their youth. Amish women do not view menopause as an escape from childbearing or a sign that they are aging. Many of the women interviewed experienced childbirth after the age of 40 and expressed the belief that these young children maintained their youthfulness. The Amish do not experience the "empty nest syndrome." While Amish women are not exempt from psychosocial disruption, decline in health, or depression, the women who described problems with depression and anxiety were more likely to relate a decline in their health status or other psychosocial issues. Many women expressed the thought that the transition into menopause had changed little in their daily lives, although they would like to be able to slow down and have some time to focus their energies on themselves.

Further research among the Amish women should explore the impact of later life pregnancy on transitional symptoms, the average duration and onset of the menopausal transition, and the occurrence, severity, and usual treatment of transitional symptoms.

TABLE OF CONTENTS

CHAPTER ONE
INTRODUCTION

One of the least understood periods in a woman's life is the menopausal transition, the time period around menopause (North American Menopause Society, 2000) marked by a change in regularity and flow of the menstrual cycle (Schott, 2000; Taber's, 2001) due to a process of gradual depletion of ovarian follicles leading to eventual cessation of ovarian function. However, there is no clear or accepted definition of the menopausal transition (Taber's, 2001) with many health care providers and researchers using the terms menopausal transition, perimenopause and menopause interchangeably.

The menopausal transition is a natural phase of a woman's life presenting her with both physiological and developmental issues. While a small majority of women may need medical intervention, most women have the capability for self-care and health promoting activity during this transitional phase (North American Menopause Society, [NAMS] 2000). Women may believe the symptoms they are experiencing constitute a medical problem and doubt their ability for self-care. They may be misinformed or receive conflicting information from their health care providers, the media, and friends (Huffman & Myers, 1999; Kittel, Mansfield & Voda, 1998). Concurrently, health care providers may assume their clients have a broader knowledge base then they actually do (Aber et al., 1998) resulting in inadequate provision of information.

Studies exploring the menopausal transition have focused mainly on the symptomatology of this transitional phase. Most researchers agree the most reported symptom is menstrual irregularity (Kittel et al., 1998; Li & Holm, 2000; Li, Holm, Gulonick, Lanuza, & Penchufer, 1999, McKinlay, Brambilla, & Posner, 1992; Schott-Baer & Kotal, 2000). McKinlay et al. (1992) found the average age and length of the menopausal transition to be 47.5 years of age with an estimated median length of 3.8 years. Vasomotor symptoms, especially hot flashes, were present in most women, but again researchers were not in agreement regarding severity (Li & Holm, 2000; McKinlay et al., 1992). Studies have shown that psychological well-being and depression are

influenced more by psychosocial factors than by the menopausal transition itself (Bromberg et al., 2001; McQuaide, 1998; Van Hall, Verdel, & Van Der Velden, 1994). Researchers are divided on the amount of depression among menopausal transition women (Busch & Zonderman, 1994; Tam, Stucky, Hanson, & Parry, 1999). Self-care actions were found to be effective for most women (Schott-Baer & Kotal, 2000), but many women are also embarrassed and use concealment about this transitional change (Kittle et al., 1998). Cultural studies generally revealed that women believe the menopausal transition is a natural phase (Berg & Lipson, 1999; Bueche & Gelser, 1997; Carolan, 2000; Chaiphibalsarisdi, 1990; Chang & Chang, 1996; Im & Meleis, 2000; Sampselle, Harris, Harlow, & Sowers, 2002; Tsao, 2002), but must be understood by health professionals in the framework of each woman's culture (Bueche & Gelser, 1997).

According to the researchers who conducted the North American Menopause Study (2000), the menopausal transition is a little studied area in need of research in all areas. The menopausal transition needs to have standardized definitions (Avis, 2003; McKinlay et al. 1992) to aid in selection of study participants allowing for results more specific to the menopausal transition female vs. the menopausal female. Studies on the usual sequencing of symptoms would provide both the health care provider and the woman in menopausal transition advanced warning of the approach to menopausal transition and the changes that are naturally occurring (McKinlay et al. 1992) allowing for better discussion and decision making. Sexual health and quality of life issues are also lacking in the research (Li & Holm, 2000; Li et al. 1999). Li et al. (1999) showed the beneficial effects of exercise for women in the menopausal transition, although the level of activity to achieve and maintain the effects must also be decided. Few studies have looked at empirical evidence about the use of and effectiveness of specific self-care actions (Schott-Baer & Kotal, 2000). Cultural studies have mostly focused on groups living outside the United States or on immigrants to America. No studies were found that focused on cultural groups that settled the New World, but have maintained their culture. The Amish, having come to America during the 1700-1800's, are one such group. Studies about the Amish, from their emic perspective, are scarce. Studies of Amish women are lacking, especially in the area of the menopausal transition and menopause. Nothing is

known about what the menopausal transition might mean to a woman in a culture where high parity imparts status.

Purpose Statement

The purpose of this study was to explore the meaning of the menopausal transition in Amish women. For this research, the menopausal transition was defined as the time period around menopause (North American Menopause Society, 2000) marked by a change in regularity and flow of the menstrual cycle (Schott, 2000; Taber's, 2001) due to a process of gradual depletion of ovarian follicles leading to eventual cessation of ovarian function. Most women experience these changes at 47.5, $\pm$3.8 years (McKinlay et al. 1992) with complete cessation of menstruation at around age 51. Using in-depth interviews, each participant was asked to respond to the question, "As you think of your experiences going through the 'change of life', what specific things stand out for you?"

Stance of the Researcher

I believe each person has dignity, freedom, and potential to achieve goals, responsibility for their own actions and capability for rational thought (Bilitski, 1981). These capabilities of the person are described by Falk-Rafael (2001) as empowerment, an "active, internal process of growth that was rooted in one's own culture/ religious/personal belief systems" (p.4).

I believe nurses have these same characteristics, but have expanded knowledge and ability to incorporate, into the nursing process, all of the factors that may affect the health of the person. The nurse is able to maximize the health potential of the person by manipulating both the internal and external resources of the person to promote self-care (Bilitski, 1981). Nursing includes those actions that promote health in the person and improvement in the person's care and environmental resources. I believe nursing should empower the person by facilitating an awareness of personal strengths and weaknesses and their right to have control of personal health issues (Falk-Rafael, 2001) in accordance with their own culture/ religious/personal belief systems.

I believe health is a continuum, a comparative concept allowing for more or less. People may be free from disease, but not healthy due to environmental issues, such as

lack of food, poor air quality, lack of recreation or exercise, and/or lack of education. Nursing must view health in the broader context, including how the environment and health affect the person. Nursing is concerned with the individual in regards to his or her health, knowing the impact the environment can have on the individual and health, and the constant interaction that occurs between the environment and person (Fawcett & Malinski, 1999; Fawcett, 2000). Because I believe the above, and that all persons experience their own reality or meaning within the context of their environment or world, which includes their culture and religion as well as physical environment, I chose to use existential phenomenology, a qualitative approach, to examine the experience of menopausal transition by Amish women.

Research Framework

The phenomenon of interest for this study was the Amish woman's experience of the menopausal transition. Because insight into a woman's understanding and perspective of the experience of menopausal transition was desired, an existential phenomenological approach was thought to provide the most appropriate research framework for this study. Phenomenology seeks to determine the personal meaning and understanding of individual experiences by listening to participants' describe how some experience is lived and felt. The commonalities and differences between various women are then woven into a composite description of experience in which others who have had the perimenopausal experience may be able to identify themselves.

Existential phenomenology is the study of the personal meaning of a phenomenon. Phenomenology desires to put the meanings of the experience back into existence (Merleau-Ponty, 1962) and to try "as hard as possible to *describe* our human experiences in precisely the ways they appear or are experienced or felt by us" (Hersch, 2003, p.47). Existential phenomenology seeks to discover "not only a change in what one thinks, but how one thinks and feels" (Valle et al., 1989, p xiv) while gaining a broader understanding of "the basic structures, elements, relationships, and meanings seen as essential or necessary to experience such phenomenon" and allowing for a more precise understanding of the phenomenon's essence. (Hersch, 2003, p. 47). Phenomenology also provides for a constantly changing view of what is human reality (Hersch, 2003).

Phenomenology emerged at the end of the 19th century as a response to positivism, objectivity, and the Cartesian ideas of dualism (Valle et al., 1989 Existentialism, founded by Kierkegaard (Valle et al., 1989), and phenomenology, founded by Husserl, both seek to describe "human life as it is lived and reflected upon in all of its first person concreteness, urgency, and ambiguity" (Pollio, Henley, & Thompson, 1997, p. 5). Heidegger, a student of Husserl, is credited with combining the two philosophies, but it was Merleau-Ponty who further expanded the ideas of existential phenomenology that form the philosophical basis for the methodology of this study (Thomas & Pollio, 2002).

Merleau-Ponty's (1962) phenomenology is existential in the sense that it deals with people in a world that existed before them and will continue after them. Phenomenology is then a search for the essence or meaning of a phenomenon experienced as part of the lived and experienced world of the individual. It is in the world the individual learns about himself or herself and then being in and of the world is known as intentionality.

The concept of intentionality is central to existential phenomenology. Pollio et al. (1997) describes intentionality as "a basic structure of human existence that captures the fact that human beings are fundamentally related to the contexts in which they live" (p. 7). Intentionality creates a world in which no objects or persons are by themselves. All experience is situated in the world. The person and world are believed to co-constitute each other, having no existence apart from the other. The world gives meaning to the person's experience, and the world would not be the same without the person (Valle et al., 1989). Intentionality is the basic structure of human experience and emphasizes the directional nature of human experience as we deal with objects, events, and phenomena in the world and reveals an essential interconnectedness between the world and us (Merleau-Ponty, 1962). Heidegger called this interconnectedness "being-in-the-world" (Valle et al., 1989).

The figure/ground metaphor further explains how the individual and world co-constitute one another (Pollio et al., 1997; Thomas & Pollio, 2002; Valle et al, 1989). The well-known "vase and face" drawing portrays a central white object on a black background that may be perceived as a vase against a black background or as two black

faces separated by a white chasm. Neither the face nor the vase can be visualized without the other as background. So it is with people and their world; all experience is perceived against a background of something. Both the experience and background are present simultaneously, although only one is seen at any one time against the background of the other, but both are necessary to define the experience. The experience is present only because there is a background to support it. Each is totally dependent on the other for existence. Phenomenology requires us to view the object (phenomenon) within the context of the object's world as they mutually support and define each other.

Embodiment, another concept of existential phenomenology, is part of being-in-the-world. Embodiment is experiencing and understanding the world by and through the body (Thomas & Pollio, 2002), especially through perception, emotion, language, space, time, and sexuality (Merleau-Ponty, 1962). Embodiment means being situated in the world during a state of continual change and being affected by social, cultural, political, and historical forces (Thomas & Pollio, 2002). Embodiment requires us to view human action and experience together, never separately (Valle et al., 1989). The body, itself, is finite and only finds its meaning and purpose by and through the world (Merleau-Ponty, 1962; Valle et al., 1989). Our senses heighten the experience of embodiment by allowing us to touch, taste, feel, and see the world around us and experience the sensations provided by the world. To be embodied is "to live in a world of fundamental interconnectedness; a world in which what we do is influenced by, and has influence upon, what others do" (Halling & Nill, 1989, p. 191).

Merleau-Ponty's (1962) thoughts about the body differ from medicine. Medicine views the body as an object that takes up space and is subordinate to the laws of science. The body as an object is a mechanism that is capable of being repaired and replaced (Thomas & Pollio, 2002). Merleau-Ponty believed the body is the core to personal existence. As such, it is the means through which the world exists and through which the world is understood. The body describes and is required to participate in each human experience. Without this participation there is no worldly experience. This embodied

existence is fundamental to human life as it is lived. My body is then mine and I am my body (Thomas & Pollio, 2002).

Drawing on phenomenological philosophy, a research method has been developed at the University of Tennessee for eliciting descriptions of lived experience. This method is well suited for studying nursing phenomena (Thomas & Pollio, 2002) and allows the researcher to "discover the interrelatedness of diverse phenomena from a broad holistic and changing perspective" (Leininger, 1985, p. 1) This perspective allows for cultural understanding, exploration of new areas of knowledge, and an ability to gain insight into client experiences. Nurses desire to view their clients in the world in which they are situated: physically, mentally, spiritually, socioculturally, and developmentally (Freese et al., 1998). The concepts of health and illness and how we respond to those concepts "are embedded in the cultural values, religious views, and economic conditions, and social environment of human expression" (Leininger, 1985, p. 2). Phenomenology allows the nurse researcher to study human experience based on details obtained from participants (from within their world), while viewing them holistically (Thomas & Pollio, 2002).

Delimitations and Limitations

This study describes the lived experience of Amish women in the Midwest who were experiencing menopausal transition. This study confined itself to interviews with a sample of menopausal transition Amish women who agreed to discuss their experience with the researcher.

The interview results are specific to this sample. The phenomenological approach does not seek to establish relationships between specific variables; rather analysis is designed to reveal the structure of the lived experience as related by women in the menopausal transition. Studies of similar samples could potentially have different results. Interpretation of results could also vary depending on method of analysis, although some meaningful similarity across studies is to be expected.

Significance of the Study

This study of menopausal transition in Amish women is important for several reasons. First, this study expands our understanding of the menopausal transition and extends our current knowledge about this phase of life. Second, the results inform clinical practice about the Amish culture. It is important to discover the similarities and differences among women from many cultures to establish a body of knowledge that allows the nurse to provide culturally sensitive and compassionate care during the menopausal transition. Clients tend to respond more favorably to nursing care when their values and beliefs are recognized and respected. Finally, Amish women have used natural self-care measures for generations. Further research may increase our understanding of self-care measures and their effectiveness for certain symptomatology.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this chapter is to describe what is known about the menopausal transition, to review research findings that are foundational to the present study, and to make recommendations about future research in this area. The pros and cons of hormone replacement therapy will not be discussed. Reports of women's symptoms and self-care practices during the menopausal transition will be reviewed. The religious and cultural beliefs of the Amish people will then be discussed as well as research findings in the area of health promotion, self-care, and other health issues among the Amish, particularly Amish women.

Review of the Literature

CINAHL, ProQuest, and Medline were used to search the literature regarding the menopausal transition, using the years 1990-2003. One hundred thirty-one articles were found: of these 98 were from 1992 or later. Most articles were informational and focused specifically on issues of hormone replacement therapy. Only 34 were actual research articles relating to the menopausal transition. CINAHL, ProQuest, Medline, and Expanded Academic were used to search the literature for Amish research through January, 2004. Approximately 450 articles were found. Most of the articles were related to cooking, quilts and local news and, therefore, not pertinent to the present study. The review will be organized as follows: a description of the menopausal transition, symptoms, current treatments, a description of the Amish and their religious/cultural beliefs, health promotion and care, and implications for practice and future research.

Description of the Menopausal Transition

McKinlay, Brambilla, and Posner (1992) were, for the first time, able to define the menopausal transition as to age and length. McKinlay et al. surveyed a cohort of 2,570 women, age 45 to 55, every 9 months for 5 years. With a retention rate of 94-99%, the researchers determined that the median age for the menopausal transition was 47.5 years of age with an estimated median length of 3.8 years. Nulliparous women and smokers were found to experience the transition at an earlier age ($p<0.001$). Smokers and

women who were older at onset of menopausal transition were found to experience a shorter transitional phase. This study followed a large enough number of women long enough to obtain strong data to support these numbers. Data collection was started with premenopausal woman so even though the data is based on self-report the study was not retrospective like many of its predecessors.

Palmer et al. (2003) explored predictors of the onset of natural menopause in African American women using a subset of 17,070 women who were already enrolled in the Black Women's Health Study. The women, who were age 35 to 55 years old, were sent questionnaires to ascertain their menopausal experience. The investigators found the average mean age at natural menopause for the African American woman was 49.6 years (SD=3.71), with smokers experiencing an earlier menopause (hazard ratio of 1.43 and a confidence interval of 95%). These results add support to McKinlay, Brambilla, and Posner's (1992) findings. This study was limited by the inclusion of a large number (12,796) of women who were still premenopausal at the conclusion of the study.

One hundred eighty four women from the Seattle Midlife Women's Health Study, who did not use hormones, were questioned by a team of researchers about menstrual cycle changes to evaluate menopausal transition. The researchers defined three levels of menstrual change in the transitional phase: early, middle and late. Early was defined as change in amount of menstrual flow, number of days or length of cycle, middle as irregular menses with no missed cycles, and late as change in flow, number of days, and length of cycle along with missed cycles. The researchers believed their study would have been stronger with a larger number of women and the inclusion of women under the age of 45 (Mitchell, Woods, & Mariella, 2000).

Symptoms of the Menopausal Transition

Most research done in this area has focused on symptomatology. Researchers tend to agree that menstrual irregularities and amenorrhea are the most worrisome symptoms (Kittel et al., 1998; Li & Holm, 2000; Li, Holm, Gulanick, Lanuza, & Penckofer, 1999; McKinlay et al. 1992; Schott-Baer & Kotal, 2000). Other menopausal transition symptoms are divided into two categories: vasomotor and psychosomatic. Sexual

changes and concerns could be another category, although little research has been done in this area (Li & Holm, 2000). More symptom reporting was found in the menopausal transition woman than in the pre or postmenopausal woman (McKinlay et al., 1992; Schott-Baer & Kotal, 2000). In an exploratory study, using a convenience sample, Schott-Baer and Kotal (2000) did find that women on hormone replacement therapy (HRT's) tended not to report as many symptoms as unmedicated women, but the difference was not statistically significant.

Menstrual Irregularity

Menstrual irregularity is a common complaint of the menopausal transition. In a cross-sectional study of 214 women, age 40-55, who were experiencing changes in menstrual patterns, Li and Holm (2000) found 9 of 10 women complained of infrequent menstrual flow and 50% reported excessive bleeding. One third of the women with excessive bleeding reported this to be extremely distressful. This study excluded women on hormone replacement therapy (HRT) or low dose oral contraceptives (OCP's), allowing analysis of data undistorted by exogenous hormonal influence.

McKinlay et al. (1992) observed that the longer the menopausal transition, the higher the physician consult rate. The irregularity and heavy menstrual flow with periods of amenorrhea were reported as more troublesome than hot flashes, especially if the cycle lasted longer than a year. McKinlay et al. also found that nearly 10% of the women they studied did not experience the menopausal transition, but ceased menstruating abruptly and moved directly into menopause.

Using 1778 women from the National Survey on Health and Development in Britain, Frohlich, Kuh, Hardy and Wadsworth (2000) tried to predict menstrual pattern changes and entry into menopause based on earlier health and behavior patterns. Three groups were identified based on menstrual pattern changes: the least, the most, and no or little change. The "least menstrual pattern change" group was more likely to be nulliparous, underweight or smokers, and women who reported less flow, frequency and duration of menses. Frohlich et al. also found that women who were nulliparous and/or smokers came into menopause significantly faster with a shorter transitional phase,

supporting McKinlay et al.'s (1992) findings. Frohlich et al. also found that women who were underweight tended to have a shorter transitional phase and earlier menopause. The "most menstrual pattern change" group reported hypermenorrhea, metrorrhagia, and menorrhagia in the first year of the menopausal transition. The "no or little change" group experienced little if any change in their menstrual patterns. The "no or little change" group has not been previously observed in other studies, with the researchers speculating this finding could be due to this group of women being less likely to report or visit a health care provider. This study was limited by the use of British women who may have other patterns of seeking health care and the study was restricted to the first year that women reported symptoms of the menopausal transition, a fact that excluded many women from the analysis, since the average transition lasts almost four times that long.

Vasomotor Symptoms

Hot flashes are the most frequently reported vasomotor symptoms (McKinlay et al., 1992). McKinlay et al. found that hot flashes, cold sweats and insomnia were three symptoms frequently cited together. Twice as much insomnia was reported in women with hot flashes, which the researchers believed was due to hot flashes and cold sweats during the sleep cycle. Hot flashes seemed dependent on length of the menopausal transition, with 39% of women who experienced a short transition reporting hot flashes versus 51% reporting hot flashes in the longer transitional group. Hot flashes were also indicators for women seeking health care, with 50% of the women who experienced longer hot flashes seeking a consult. Women who experienced few or no hot flashes usually had a shorter menopausal transition or experienced an abrupt cessation of menses. Hot flashes were found to decrease with post menopause. McKinlay et al. reminds us that hot flashes are not exclusive to women or to the menopausal transition with at least 10% of the general population also experiencing hot flashes. In the cross sectional study reported earlier, Li & Holm (2000) found that the majority of women did not find hot flashes to be troublesome; however, the data may have been skewed by the exclusion of women on HRT.

Matthews, Wing, Kuller, Meilahn and Plantinga (1994) tried to determine changes in cardiovascular risk factors and psychological/physical symptoms in a randomly selected sample of 162 women experiencing symptoms of the menopausal transition. Triglycerides were found to be higher in transitional women, but total cholesterol, LDL, HDL, fasting glucose, systolic and diastolic blood pressure, and weight were similar to premenopausal women. However, the researchers did find lower estradiol levels in women who complained of hot flashes.

Psychosomatic Complaints

In the only study of its kind, Van Hall, Verdel and Van Der Velden, (1994) compared men and women in regard to specific psychosomatic complaints usually attributed to the menopausal transition or to menopause. Using 8,679 women and men aged 25-75, these researchers found the common transitional complaints, (dizziness, headache, tiredness, nervousness, aggressivity, irritability, incontinence, joint pains, transpiration, palpitations, insomnia and listlessness) were neither age or gender specific. The researchers hypothesized that, with 80% of the women reaching menopausal transition between the ages of 45-55, there should be a corresponding rise in psychosomatic complaints in this group. However, they found no corresponding rise in complaints and concluded that even though females, throughout their life span, tend to report more psychosomatic complaints than men, the women experiencing menopausal transition were no different than any other age group. The only exception to this was the report of excessive sweating. Van Hall et al. concluded that their research supported the idea that the climacteric and menopause do not have a major effect on the midlife woman's well being, with psychosocial factors being the more likely cause of distress.

McQuaide's (1998) study concerning psychological sources of well-being supports Van Hall et al. conclusions about psychosocial factors. A questionnaire about attitudes, beliefs, and feelings about midlife was distributed to 103 women who were recruited through ads and posters in various buildings and offices. Almost 73% of the women reported high levels of well-being despite 39.2% of them reporting problems coping with menopausal transition symptoms. McQuaide (1998) also found the major

predictors of well-being were an annual family income greater than $30,000, having a confidante or a group of female friends, and good health. The higher the level of health, the greater the reported level of well-being. Marital status, employment status (unless the woman was forced to resign), sexual orientation, and number of children at (or not at) home did not influence the level of well-being. However, current and recent stressors correlated negatively (r=-.42) with well-being. McQuaide (1998) subsequently used a qualitative technique to ask 10 high and 10 low scorers about their quality of life. The researcher found the high scorers had positive images of midlife and reported liking the increased independence and freedom that allowed them to explore new options. The low scorers had a more negative outlook about midlife, believed themselves to be ruled by others, and doubted themselves. This study was strengthened by factor analysis of the measures of each variable and strong statistical methods. However, it was limited by the use of a self-selected group.

Bromberg et al. (2001) supported the conclusions of McQuaide (1998) and added a cultural component by exploring the relationship between psychosocial factors and psychological distress in a multicultural group of 10,374 women aged 40-55 (mean age 45.5). These researchers discovered that White, Hispanic, and African American women who were in early menopausal transition reported the greatest amount of psychological stress. Hispanic women also reported the poorest health and the least amount of support. Both Hispanic and African American women reported the greatest financial strain. The Japanese and Chinese women studied were found to have the most reported support and the lowest odds (0.43 odds) for psychological distress. Multiple logistic regression analysis excluded marital and employment status, physical activity, and medical conditions as significant variables contributing to psychological distress. Bromberg et al. (2001) concluded that psychosocial factors related to race/ethnicity contributed to the psychological distress of the women. However, the study had several limitations: the use of menopause and menopausal transition interchangeably; measurement of psychological distress by a tool that was not standardized and validated; lack of income identification; and the failure to query participants about stressors.

Using a cross-sectional, correlational study, Li et al. (1999) explored the relationship of exercise and menopausal transition symptoms in 214 women. The researcher found relatively active-to-active women experienced and reported fewer psychosomatic symptoms and reported menopausal transition was not a major subjective health problem. Women who exercised less or not at all reported psychosomatic symptoms more often and even reported them as more distressful than vasomotor symptoms. Menstrual irregularity was the most frequently reported symptom and vasomotor symptoms the least reported. Exercise did not seem to help the vasomotor symptoms.

Depression and Memory Functioning

The menopause transition/menopause has long been stereotyped as a depressive time in a woman's life. The results of studies in this area have varied. Studies from the 1970's (Crawford & Hooper, 1973; Van Keep & Kellerhals, 1974) hypothesized that middle-aged women experiencing the "empty nest syndrome" were more depressed and suffered an increase in menopausal symptoms. Other researchers (Jaszmann, Van Lith, & Zaat, 1969) found women who have children after the age of 40 and thus have children in their home during midlife had fewer symptoms than women who had children earlier in their life. During a ten-year follow-up of the National Health Examination Study, Busch and Zonderman (1994) found no increase in depression, poor psychological well-being or sleep disturbance in 3,049 women aged 40-60. Interestingly, they did find a slight decline in depression. The numbers of women studied and the time period followed provided for adequate data to support the conclusion that menopausal transition/ menopause does not equal depression.

Woods and Mitchell (1997b) expanded on the assumption that menopausal transition/ menopause does not equal depression. Using 337 women from the Seattle Midlife Women's Health Study, they tested the ability of menopausal transition, a stressful life, and health status to predict depressed mood. These three paths were tested as a multidimensional model of depressed mood. The model, with a goodness of fit that was greater than .90, found that stressful life context and health status had a significant

direct effect on depression, but the menopausal transition had no explanatory powers for depression. The researchers also found that women who were experiencing menopausal transition and increased stress in their life also experienced more vasomotor symptoms, while those who had better health and a positive socialization had less stress and fewer vasomotor symptoms. The researchers concluded that depression in midlife is more likely the result of a woman's health status and the negative impact of our society's attitudes about midlife than the midlife transition itself.

Tam, Stucky, Hanson and Parry (1999) found a higher depression score, obtained with the Beck Depression Inventory (BDI), in menopausal transition women than in pre and postmenopausal groups. Half of the transitional group met the criteria for a major depressive disorder. Generalizability of the study was limited, however, because subjects were recruited out of physicians' offices. People with stronger depressive feelings would be more likely to respond to the questionnaire. As McKinlay et al. (1992) pointed out, women who perceived their symptoms to be more problematic are more likely to seek out a health care provider.

Using the Memory Functioning Questionnaire, Woods, Mitchell and Adams (2000) explored women's perception of memory functioning as they aged. Two hundred five sample participants were obtained from the Seattle Midlife Women's Health Study, with a mean age of 46.7 years, 15.9 years of education, and a median income of $42,000 annually. Of this number, 40 women used HRT. Participants provided annual data, menstrual and health diaries, and monthly urine specimens to determine endocrine assays. The most frequently reported memory problem was remembering names, with 72% noting this as a problem, but only 32% felt this was a significant problem. Overall, there seemed to be a general agreement that menopausal transition memory functioning was not a problem. Women who used HRT recorded the greatest problem with memory functioning ($p<0.009$), as did women who used anti-depressants. Perceived memory functioning is closely related to how the woman perceives her overall health, mood and stress. The more positive the women felt about their overall health, the more positive they saw their ability to remember.

To explore memory change further, Mitchell and Woods (2001) interviewed 230 women enrolled in the Seattle Midlife Women's Health Study. The women were asked to describe the perceived type of memory loss and the attributions of the loss. Sixty-two percent of the women reported undesirable memory change that increased with age, with difficulty remembering words/numbers the number one reported difficulty followed by names and phone numbers. The women explained this change by implying increased role burden or stress and getting older. No one attributed the loss to menstrual cycle changes. This study was limited by the use of the perception of memory change instead of standardized memory testing, retrospective collection of data, narrow age range, and women who were interested enough in the subject to remain in the study over a period of years.

Sleep Disturbance and Quality of Life Issues

Sleep disturbances were reported by McKinlay et al. (1992) and were believed to be due to hot flashes. However, using a correlational field survey, Clark, Flowers, Boots and Shettar (1995) found no significant relationship between sleep disturbance and menopausal transition. The researchers challenged hot flashes as a cause, but believed periodic limb movement was responsible; however, the study was limited by a small sample size of 23 women.

The members of the North American Menopause Society (NAMS) (2000) formed a panel of experts in the area of menopause to address the "clinical challenges of perimenopause". Using a Delphi study approach, the NAMS members described 3 common patterns of sleep disturbance: difficulty falling asleep, early morning awakenings or awakening in the middle of night and an inability to return to sleep. The members cited a need to look at other factors as causes for sleep disturbance such as hypothalamic disturbances; poor sleep habits such as daytime naps and an irregular sleep schedule; stimulants like caffeine, alcohol, nicotine and certain prescription medications; and illnesses including chronic disease. NAMS members also agreed that sleep disturbances could seriously affect quality of life. The major drawback to the work of the

NAMS members is that they used the Delphi approach to achieve general consensus, and conducted no actual research on the menopausal transition women.

Li et al. (2000) conducted a cross-sectional, correlational study of 214 menopausal transition women who did not use HRT's or OCP's. The study's purpose was to address quality of life issues. Each woman completed the Women's Health Assessment Scale and the Quality of Life Scale for premenopause and transition to menopause. Comparing each woman's retrospective perception of premenopausal quality of life with their present menopausal transition quality of life, the researchers found that 45% of the women reported a slight, but significant ($z=-6.97$, $p<0.001$) decrease in reported quality of life, while 50% of the women reported no change. The researchers believed this decrease was most likely due to the range of symptoms the woman may experience during this transition. A significant limitation of this study was the use of retrospective data.

Woods and Mitchell (1997) explored quality of life by exploring the meaning of midlife to a sample of 131 women who were already participating in the Seattle Midlife Women's Health Study. The women were well educated, with a median grade completion of 15 years, median age of 41 and racial/ethnic group proportions representative of the surrounding area. Using phone interviews, the women were asked open-ended questions to determine their beliefs about midlife. Five themes were found in the interviews; change/transition, midlife as half lived and half left to live, goal attainment and appraisal, and the reality of vulnerability to poor health and death. The researchers concluded that concerns of the women about transitions, growing older, and vulnerability to poor health and death were no different then previous studies. However, they did find women of today expressed a higher quality of life then previous generations, which they attributed to interests outside the home such as personal achievements and employment. Interestingly enough, family and spouses were still their major concern and focus.

Sexual Dysfunction

Li et al. (2000) also found that a decrease in sexual desire was the most frequently reported sexual symptom among menopausal transition women with 57.4% reporting

having experienced a decrease in desire from "sometimes" to "always". Forty-five percent reported this to be "quite" to "extremely" distressful. The second most frequently occurring symptom was vaginal dryness, with painful intercourse less frequently reported and less distressful. Sexual problems were less distressful then vasomotor or psychosomatic symptoms.

Current Treatment for Menopausal Transition

The NAMS members (2000) concluded, using the Delphi aproach, that the majority of menopausal transition women do not require specific medical management. All agreed that screening, counseling, and lifestyle changes are adequate treatment for most women and should be initiated before the menopausal transition. A small number of women may benefit from the addition of HRT. The society also suggests that healthcare providers should consider extrapolating data on postmenopausal women when treating the transitional woman, since little research has been done in the area of menopausal transition. Members of NAMS achieved consensus that no treatment is necessary for amenorrhea if the woman ovulates periodically (2000). They also agreed that nonopioid analgesic/nonsteroidal anti-inflammatory drugs (NSAIDS) could reduce the heavy menstrual bleeding associated with menopausal transition. The NAMS members then extrapolated all findings for menopausal women and recommended the use of HRT to control vasomotor symptoms, sleep disturbances, and sexual dysfunction even though they were the first to admit that no studies have been done to determine the effect of HRT on the transitional woman.

Estrogen and HRT have long been the mainstay of treatment for menopause and menstrual irregularity. In a longitudinal study of 2,425 women, aged 45-55, Johannes, Crawley, Posner and McKinlay (1994) found the overall usage of HRT to be 12.3%. Surgical menopause accounts for 45% of this number. Predictors for a woman starting HRT's included talking with a healthcare provider within the previous 2 weeks or having had a discussion about menopause in the past 9 months. Johannes et al. examined the characteristics of the women started on HRT's and found that these women tended to utilize health care more frequently and were more likely to be on another prescription

medication. Women who had more education, usually greater than 12 years, were less likely to discontinue HRT's.

In another study, 400 randomly selected women, between ages 45-54, were mailed questionnaires with a response rate of 68% (Anderson & Posner, 2002). The questionnaires asked a wide range of questions about attitudes towards menopause, social functioning, mental health, vitality, preventive health practices, and lifestyle factors (Cronbach's alpha 0.85). Almost 42% of the women responding had used HRT at some time with 20.4% reporting current usage. The researchers also found a slight relationship between age and HRT with approximately 22% of the women over the age of 50 using HRT. Other predictors of HRT use included the expression of a negative attitude about menopausal transition/menopause and complaints of low vitality, neither being relieved by HRT, and breast examinations within the previous 12 months (Anderson & Posner, 2002).

Twenty-one well-educated women, aged 42-53, were interviewed about their beliefs and their decision making process in regards to HRT (Andrist, 1998). All of the women were college graduates, with 17 of the 21 having advanced degrees. Eleven women were health care professionals. Andrist (1998) found vasomotor symptoms to be the compelling factor for 6 women in their decision to take HRT, with 3 reporting they would continue to use HRT for long-term prevention of disease. However, 10 women were undecided about starting HRT and cited poor scientific knowledge, not enough information provided, or conflicting information presented by the media and health care providers. Five women were opposed to HRT stating they had no risk factors and menopause was a natural transition in one's life making it seem inappropriate for them to take medication. This study was limited by the small sample size and sampling bias based on educational level.

Langworth (2003), using a nonexperimental pilot study, explored the factors that influence Hispanic women's decisions to initiate or decline hormone replacement therapy (HRT). Fifty-one Hispanic women were asked to respond to the Spanish version of the Menopausal Decision-Making Questionnaire with 42 women actually completing the

initial questionnaire and 39 completing the posttest questionnaire. The majority of the women were poor (72%) and more than half had not completed high school. The researcher discovered that the majority of Hispanic women express a positive perspective about the transition and menopause, believe their menopausal symptoms are minor and do not desire HRT for relief of those symptoms. However, a large number of women admitted to a general lack of knowledge about this phase of their life and believed any associated health risks to be relatively low. This study was limited by the small sample size, the use of women who were not currently experiencing the menopausal transition, and a sample with a predominately low income and little education. The researcher encouraged further studies with larger numbers of Hispanic women to verify the results of the pilot study. The researcher also suggested a qualitative study be undertaken in this population so the women could more fully describe their experience with and perception about the menopausal transition.

The Women's Health Initiative {WHI, (2002)} was a randomized, controlled trial designed to investigate the use of combination hormone therapy as a preventive for coronary artery disease and hip fractures. The WHI enrolled 16,608 women aged 50 to 79 years of age, who were given either a combination hormone or a placebo. After an average of 5.2 years observation, the study was halted because the investigators believed the risks of combination hormone therapy outweighed the benefits. Participants using the combination hormones demonstrated a 26% increase in breast cancer, a 41% increase in stroke, a 29% increase in coronary heart disease, and a 110% increase in thromboembolic events. The researchers concluded that combination hormones should not be used as preventive therapy for cardiovascular disease and suggested that 5 years should be considered the optimal period for combination hormone use.

The feminist view on menopause has long decried the medicalization of menopause and the promotion of more youthful, feminine/sexual bodies by the use of hormone therapy (Gullette, 2003). Feminist argue that the involvement of doctors, diagnostic tests, unfamiliar language, surgeries, and drugs have further removed women from the naturalness of life events and made them seem mysterious and strange,

something that must be medically supervised (Tiefer, 2002). The feminist view implores us to explore women's health and well-being as embodied experiences, not just a biological event.

Self-Care Practices of the Menopausal Transition Women

To determine the self-care actions and the effectiveness of these actions in the menopausal transition, 462 women, over the age of 40 were surveyed to determine the (a) frequency of menopause-specific symptoms and (b) self-care measures employed (Schott-Baer & Kotal, 2000). Menopausal transition women were found to report more symptoms than the pre or postmenopausal women ($F = 13.25$, $p < 0.01$). Using ANOVA to compare scores across the 3 groups, the researchers discovered that the most frequently used self-care actions were to control vasomotor symptoms through adjusting to the environment. Women using HRTs most often layered clothes, while the non-HRT group turned down the thermostat and sought more information. Both groups avoided hot flash triggers and used calcium supplementation. Many women in the non HRT group also used vitamin B6. The effectiveness of these self-care actions was reported as positive, with no difference in effectiveness for either group. However, women taking HRTs reported HRTs as the most effective method to deal with symptoms. Self-care measures remained the same through the pre, transitional, and postmenopausal period. Schott-Baer's study is the only one that explores the relationship between symptoms, self-care and the effectiveness of that self-care.

Using a qualitative approach, Kittle et al. recruited (1998) 61 women, aged 41-54, who had reported changes in their menstrual pattern during participation in the Midlife Women's Health Study. The women were asked to describe their self-care measures. All women were white, middle class, educated and employed. The core variable identified was that of keeping up appearances through concealment and control. The women expressed the belief that menstruation was not to be discussed and they did not want others to be aware of menstrual changes. Some women, who experienced an increase in flow or irregular menses, described how they would wear dark clothes and constantly check and watch for bleeding. Others always wore pads or tampons "just in case". All

had supplies "stashed" so they were always prepared. Women who experienced hot flashes would ignore or minimize them, if the hot flashes were unnoticed by others. Leaving the room, changing the thermostat, or applying powder concealed hot flashes that produced visible changes. Other measures used by all were layering of clothes, using fans, and avoiding possible triggers such as caffeine, wine, and stress. Some women also reported using herbal or homeopathic remedies. The women were also concerned with their emotions and keeping them in check, even concealing the emotions if necessary. Women who experienced changes that were unexplained or unexpected sought more information to explain the change. After regaining control, through self-management strategies, equilibrium was restored. Those who were unable to regain this equilibrium sought out an explanation from a health care provider. This study was limited by using all working, educated, women with the same race and level of income.

Tsao (2002) explored the experience of 30 Taiwanese women in their implementation of self-care using a grounded theory approach. Tsao found the women utilized Western and Chinese medicine in addition to their self-care measures to control bodily symptoms and discomfort. Most of the women who sought Western medical care wished to validate their belief they were experiencing menopausal transition or to reduce the suffering they were experiencing from symptoms they could not control with self-care measures. The women who sought out medical care still regulated any medications or treatments suggested by the health care provider according to their body constitution and continued to practice self-care measures. Tsao strengthened the validity of this research by conducting two interviews and continued interviewing women until the data was saturated and dense. Generalization of the study findings is restricted due to culture.

Research done by Chaiphibalsarisdi (1990) among rural Thai menopausal transition women, found findings similar to the Taiwanese women (Tsao, 2002). Using grounded theory, the researcher interviewed 20 women and discovered that the women believe menopause is natural and cannot be controlled. The use of self-care measures was based on severity of symptoms, their understanding of menopause, and their ability to perform work. Western medicine was used to confirm menopausal status and control

severe symptoms. The most frequent indicators of transition were irregularity of menstruation and hot flashes. This study was strengthened by the use of Thai language to interview the women. The study was weakened by the use of retrospective data about the menopausal transition.

More than half of the Australian women in Anderson and Posner's 2002 study (discussed on p. 21) reported using self-care measures during menopausal transition, including self breast examination (70%), regular exercise (61.1%), eating healthy foods (60.7%), and not smoking (52.6%). Approximately half of the women also believed the more interests in their lives, the less likely menopausal transition was to affect them adversely.

Cultural Aspects of the Menopausal Transition

Salmond (2000) defines culture as consisting of "shared beliefs, values and attitudes that guide the behaviors of the group members" (p. 151) which gives an individual distinction from other groups (Sitelman & Sitelman, 2000). A cultural group may be comprised of a nationality or ethnic group as well as encompassing gender, religious organizations, professional discipline, age groupings, and common health problems (Salmond, 2000). Behavioral norms and expectations are culturally defined and associated with shared beliefs and values (Salmond, 2000; Sitelman & Sitelman, 2000). Within each culture, there may exist subcultures and interconnected cultures (Sitelman & Sitelman, 2000).

Social, economic, and cultural factors have a substantial effect on the lives of women, negatively or positively impacting women's health throughout their lives. To effectively care for each woman in the menopausal transition phase of life, the practitioner must understand what this phase means to the woman both personally and culturally (Bueche & Gelser, 1997). Of the twelve cultural studies reviewed, most participants expressed belief that the menopause transition was a normal process that did not require extra attention (Berg & Lipson, 1999; Bueche & Gelser, 1997; Carolan, 2000; Chaiphibalsarisdi, 1990; Chang & Chang, 1996; Hautman, 1996; Im & Meleis, 2000; Longworth, 2003; Palmer et al., 2003; Sampselle, Harris, Harlow, & Sowers, 2002; Tsao,

2002). Australian women, discussed previously, also expressed a sense of relief at the ending of menses and childbearing, with most women generally report the menopausal transition as a time of positive social functioning and high levels of mental health (Anderson & Posner, 2002). However, many women expressed ignorance (Chang & Chang, 1996; Hautman, 1996; Im & Meleis, 2000) or embarrassment over lack of information and knowledge (Im & Meleis, 2000) with men knowing even less than the women about the experience (Berg & Lipson, 1999; Bueche & Gelser, 1997; Im & Meleis, 2000).

Using Colaizzi's method of phenomenology, Carolan (2000) interviewed 6 Irish women who lived in rural Ireland, all of whom had at least 5 living children, about their menopausal transition/ menopausal experience. Women who expressed a desire for more children were excluded. The common themes that emerged were sense of relief at the ending of menses and childbearing, menopausal transition/menopause is a natural event in a woman's cycle, satisfaction at having successfully raised their families, and the problematic symptomatology associated with menopausal transition-especially the heavy bleeding. Carolan's study supports the belief that menopausal transition is a natural event in a woman's life that must be viewed in its sociocultural context. However, this study was limited by excluding women who expressed the desire for more children, as well as women with parity of less than 5, and the use of the rural setting only.

To better understand the lived experience of the menopausal transition, Bueche and Gelser (1997) interviewed 10 Caucasian women, ages 45-55, who were not receiving hormone therapy about their experience with menopausal transition. Using Colaizzi's method to analyze the data, seven themes emerged, but were not named in the usual sense of naming themes. Theme 1 explored menstrual cycle changes and associated physical symptoms, theme 2 explored menopause in general, theme 3 placed menopause in the context of other developmental milestones, theme 4 found the desire to connect with other women and their experiences, theme 5 explored how menopausal transition impacted relationships, theme 6 described beliefs about the role of health care providers, and theme 7 discussed hormones. Overall, the researchers found the women were

satisfied with their lives; physiological and psychological symptoms could be placed on a continuum from none to a large variety; and the experience of menopausal transition was highly personal and idiosyncratic. Allowing the participants to validate that this was their experience was a major strength of this research. A major weakness was the use of mostly well-educated women, a sample where 8 of the 10 had completed some college work.

Hautman (1996) used a grounded theory method to conceptualize the menopausal transition as experienced by 16 Filipina-American women who identified themselves as transitional. The women had lived in the United States for 15-30 years. Using constant comparative analysis, the core category, changing womanhood, was identified along with 3 subgroups of change: living in my changing body, changing family relationships, and changing family networks. Many of the women experienced physical symptoms, such as hot flashes, menstrual cycle changes, and sleep disturbances. They also experienced a shift from mothering to "sandwiching", caring for children and aging parents. Many expressed the idea that the menopausal transition was a time to reflect, a shift from thinking of others to reflecting on self and the things they wanted to do, including community projects or further education (Hautman, 1996). The researchers concluded that Filipina-American women experience menopausal transition as a normal process and valued further education and health promotion in the form of classes and suggested reading. This study was limited by the use of women who have lived for 15 or more years in the United States. They may not represent the views of Filipina-American women who have lived in the United States for less time.

Berg and Lipson (1999) explored the expectations and health beliefs of 165 midlife Filipina-American women. The participants reported on how they learned and who they talked to about menopause, how they felt about menopause, and their most common health complaints. Using descriptive statistics, the researchers found that the majority of the women saw this time as a normal life phase and do not seek health care for menopausal transition symptoms, although 39% experienced hot flashes, sweats, and vaginal dryness. Many of the women (43%) learned about menopause from female

relatives and friends, while 21% used the media, especially magazines, for their information source. The researchers concluded that Filipina-American women need information about this transformation time given to them at routine health care visits. This study was limited by the use of menopause/menopausal transition interchangeably and not identifying the amount of time lived in the United States.

Using a qualitative approach, within the stance of feminism, Im and Meleis (2000) interviewed 21 low-income, Korean immigrant women, with a mean age of 49.5, who were experiencing menopausal transition. Women who could not read, speak, and write Korean were excluded. Despite the women's low-income status, they were mostly well educated with 10 women having attended or completed college, and nine women completing high school before coming to the United States. The researchers found that the meaning Korean women ascribed to menopause was deeply related to interpersonal relationships, especially relationships with their husbands and their immigration experience. The women associated the menopausal transition as an aging process in which they would experience negative physiological, psychological, and social changes. Many of the women expressed negative feelings such as "falling down a hill" and "the sunset" or totally ignoring the transition or making it "invisible" due to increased energy and thought being put into their new lives and businesses in the States. The researchers also discovered that Korean culture dictates that female issues such as the menarche, pregnancy, and menopause are taboo and not discussed openly, making the menopausal transition invisible (Im & Meleis, 2000). The study was limited by excluding women who could not read, speak, and write Korean.

Focus groups, with 30 African American and Caucasian women, were used by Sampselle et al. (2002) to explore the meaning attributed to menopause and the actual experience of midlife aging. The researchers found that both groups of women focused heavily on family relationships, especially children. The women saw the departure of their last child from the home as a release from direct responsibility for their children. Both groups seemed to recognize that they were growing older, relationships were changing, and their own mortality was in question. This realization prompted the women

to make available greater time for self-appraisal and evaluation of their life experience. Most of the women saw themselves as more productive, having greater self-esteem, and better able to accept themselves for whom they were. Despite these similarities, the ethnic groups differed on one key issue. African American women tended to define transitioning into menopause as a physiological process, one that is natural, even a welcome event. Their Caucasian counterparts voiced more concerns about the physical aspects, the aging process and the effects of aging on their body and their attractiveness. The researchers concluded that physical changes during midlife had a greater impact on Caucasian women due to the increased emphasis, within the Caucasian culture, on physical beauty and youth. This study was strengthened by the use of the women's own words to describe their experience. However, the study is limited by the use of African American women from a large town and Caucasian women from a rural area, which may have resulted in some differences.

Description of the Amish

There are many minority cultures with a variety of beliefs and customs in the United States. One rarely discussed, but rapidly growing, cultural group are the Amish. Hostetler (1980), a social scientist who grew up Amish and did much of his research living in the Amish communities and Kraybill (1989), also a social scientist who lived among the Amish, have done extensive research about Amish history and life in the United States. The Amish are a conservative Protestant group whose religion shapes and is their way of life. The Amish emerged out of the Swiss Anabaptist movement of the 16th century (Hostetler, 1980; Kraybill, 1989). They believe in adult baptism, a crime in the 16th century, and shunning, the practice of non-association or excommunication for those who forsake the Ordnung ([Ott-ning], an oral and unwritten guide for an orderly life) and refuse to repent. The Amish were persecuted and martyred in Europe. This persecution led to their mistrust of government and the "English" which has continued to this day. They migrated to America in two waves; 1727-1771, with the majority settling in Pennsylvania; and a second wave arriving between 1815-1860, settling in Ohio and Indiana (Hostetler, 1980; Kraybill, 1989). The Amish now live in 25 states, mostly east

of the Mississippi, and Ontario, with their membership approaching 180,750 (Luthy, 1997).

Religious/Cultural Beliefs

Despite the spread of Amish communities across the United States, Amish religious and cultural beliefs remain unchanged. The Amish believe in adult baptism, separation of church and state, the right to refuse to bear arms, take oaths or hold political office, shunning, and the attempt to live life in accordance with the teachings of Christ as described in the Bible (Kraybill, 1989; Schwider & Schwider, 1975). The Ordnung governs the Amish in all aspects of life and death including technology use and change (Hostetler, 1980; Kraybill, 1989). The Ordnung provides structure and boundaries that allow for the development of a sense of meaning, belonging, and identity among the Amish (Kraybill, 1989) while supporting the social order of the community (Hostetler, 1980). It also clarifies what is sinful and considered too worldly for the community. Change to the Ordnung is done on a yearly basis with equal voice for all men. Technology and change are carefully screened to prevent anything that might contaminate their values or erode the solidarity of family and community (Hostetler, 1980).

Social Organization

The family is the mainstay of the Amish social organization. Amish life is spent in the context of family; most Amish people are born at home and die at home. The family's function is procreation, nurturing, and socialization of children (Hostetler, 1980). The system is patriarchal, but family decisions are typically joint between husband and wife (Hostetler, 1980; Kraybill, 1989). Almost 74% of married men and 100% of married women work on their farm home (Kraybill, 1989). "The farm is the Amishman's kingdom, and his wife is his general manager" (Hostetler, 1980, p. 154).

Reschly and Jellison (1993) examined records from questionnaires conducted in 1935-1936, in Lancaster County, and found that little has changed for the Amish. Farming is still the Amish way of life with the men and women having separate roles. The women are active in yard work, house maintenance, and food and clothing

production. When compared to Non-Amish farms, in the same county, Amish farms were worth more, had a higher gross income, a lower expenditure for clothing and new furniture, but bought more sewing supplies. The Amish women were found to be the mainstay of the farm, were highly satisfied with their lives, and believed themselves to be equal partners with their husbands. The Amish farms did rely heavily on family labor sources.

Wasao and Donnermeyer (1996) examined family size among the Amish with respect to farm or non-farm status of the husband. Using a sample of 888 households, as listed in the Ohio Amish Directory, the researchers ascertained that fertility rates do differ and respond to the surrounding economic and cultural forces both within and without the Amish community. Three different Amish affiliations, ranging from conservative to liberal, were analyzed. The researchers found the conservative group had the largest families as did farming families and families in which the husband was a church elder. These families were two and a half times more likely to have greater than 10 children than families in which the husband worked at occupations other than farming. The sample average was 5.3 children. This study could have been strengthened by a comparison of the Non-Amish population parity rates in the same county.

There are 3 milestones in an Amish individual's life: when they are baptized, when they marry, and when they retire. The elderly in the study by Andreoli and Miller (1998) expressed the idea that elderly among the Amish are respected and well cared for, usually in their own home. If unable to care for themselves, their children, relatives, or community members will rotate their care among themselves. One elderly Amish stated that Amish elderly would rarely be put in a nursing home. Most expressed the idea that their families and communities were bound together by language, unique dress, and home worship. From the beginning of each life, the Amish are taught religious commitment and selflessness. They are taught it is a joy to put others first. As shown in the 1998 study, an elderly person believes this is why they are so well taken care of.

Crist, Armer, and Radina (2002) discovered three major themes in their case study of one Amish family, who cared for their elderly father with Alzheimer's disease. The

foremost theme was a respect for the elderly regardless of illness or frailness. Other themes were the manipulation of the environment to promote safety while maintaining self-autonomy and the constant support and care of the extended family members.

The immediate family is the hub of Amish society and includes the extended family, the community, and the church. The number of families determines church size, not individual members (Kraybill, 1989). Activities are anchored in the home. Most church districts consist of 25-40 families, all within driving distance for a horse and buggy. Church services are held on a rotating basis in individual homes (Hostetler, 1980; Kraybill, 1989). The Amish do not pay into the social system, nor do they accept public assistance or Social Security.

Health Promotion and Care Among the Amish

The Amish are very health conscious people. Levinson et al. (1989) found that Amish adults were less likely to use tobacco, and consumed less alcohol, and less salt, while using more vitamins. Favorite home remedies are readily used and passed from generation to generation (Hostetler, 1980). The Amish do not reject medical technology, but select those treatments that are congruent with their way of life (Camparella, Korbin, & Achison, 1993). They may even travel great distances seeking a cure (Hostetler, 1980). The Ordnung does not prohibit the use of modern medical services or immunizations, but many Amish are slow to accept preventive measures due to their cautious nature, issues of trust, perceived lack of integrity and sympathy on the part of modern medicine, and the belief that God created and God can heal (Hostetler, 1980). Many Amish use chiropractors because they believe the chiropractor spends more time talking and listening to them than medical doctors (Hostetler, 1980).

Dellasega, Hupcey, and Fisher (1999) explored how a group of 9 advanced practice nurses (APN'S) developed and maintained relationships with their Amish clientele. Data were collected, using semi-structured interviews, and analyzed simultaneously until saturation was obtained. Dellasega et al. found the APN's made an effort to become active participants in the community, worked at building a relationship based on trust, and delivered individualized care for each client. The APN's also continued to learn

about cultural practices and self-care measures used within the community so these measures could be safely incorporated into the client's care. Unfortunately, this study only focused on the beliefs of the APN and failed to elicit the Amish reaction to this care.

Using open-ended questions, Armer and Radina (2002) questioned 87 Old Order Amish adults, across 3 generations; young (18-39), middle (40-59), and older (60+), about their health and health promotion behaviors. The definition of Amish health was obtained by using hermeneutical and thematic analyses of the responses. Health for the Amish was described as the importance of being healthy, the ability to work hard, and a sense of freedom to enjoy life, family responsibility, and physical as well as spiritual well-being. Health promotion behaviors were categorized as exercise/physical activity and nutrition. Most of the physical activity reported was related to strenuous outdoor farm work.

Armer and Radina (2002) further expanded their study by using quantitative tools with moderate to high reliability (Cronbach's alpha, 0.767-0.88) and prior use in multicultural groups. The researchers, using ANOVA to compare means across generations, found the Amish believe that one's individual health lies with the individual and they have a high internal locus of control across all age groups, with fate playing a more important role than the action of others, including health care providers. This may account in part for the use of health care professionals only as a last resort. Perceived social support was found to be high among all age groups. This study was strengthened by the use of 3 generations. However, a major limitation of the study is the use of a convenience sample.

Von Gruenigen et al. (2001) examined the rate of utilization of complementary and alternative medicine (CAM) in 66 Amish women of which 76% were pregnant. Using a survey, 36% of the women reported using diet/nutrition programs, herbal medicine, and chiropractic visits. Forty-nine percent of the pregnant women reported CAM use. Only three women discussed CAM usage with their physician. However, this study may not be representative of the total Amish population due to use of a convenience sample.

Cardiovascular Health

A food frequency questionnaire was mailed to 250 Amish, who had participated in a previous study that measured saturated fat and cholesterol, to ascertain dietary risk factors for cardiovascular problems (Glick et al., 1998). A total of 223 responses were obtained. The researchers discovered that men consumed significantly more total fat and calories, protein, carbohydrates, saturated fats and dietary cholesterol than women. The Amish diet was then compared to a Non-Amish population from a previous study that utilized the same food questionnaire. The Amish reported a higher daily intake of calories, fat, protein, carbohydrates, and cholesterol. However, standard deviations were not available for the previous sample, so the Amish standard deviation was used for the U.S. sample, which may have altered the results. The Amish were found to be leaner and men had lower cholesterol and blood pressure then the Non-Amish men. The Amish women had similar levels of systolic blood pressure and cholesterol levels as Non-Amish women.

To further explore cardiac health, physical activity, and obesity levels in an Old Order Amish community, Bassett, Schneider, and Huntington (2004) enlisted 53 Amish men and 45 Amish women (18-75 years of age) who wore pedometers and recorded the steps they took for seven days. Each participant than filled out the International Physical Activity Questionnaire which ascertained their activity level. Anthropometric variables, body mass index, and percent of fat were than determined. The researchers discovered that 93% of the Amish studied met the 10,000 steps per day criteria for cardiovascular health, with the average number of steps for men and women being 18,425 and 14,196 steps per day respectively. Men engaged in approximately 10 hours of vigorous and 42.8 hours of moderate activity per week, while their female counterparts achieved 3.4 hours of vigorous and 39.2 hour of moderate activity per week. The researchers concluded the physical activity of the group resembles that of rural residents of North America in mid to late 1800. The researchers further found that 27% of the women and 25% of the men were overweight, while only 9% of the women were obese and no obesity was found among the Amish men. Activity levels in both the Amish men and women were well

above their North American counterparts. Unlike previous elderly population studies, the researchers found no decline in Amish elderly activity levels. This study was strengthened by the use of a questionnaire that has been validated in 21 countries/6 continents as well as industrialized vs. 3rd world countries and the use of a population whose distribution of age and gender is similar to the general Amish population. The study was limited by the absence of comparison to non-Amish farmers in the area or city dwellers, using only one season, planting season, which could be busier than other seasons, and despite the distribution of age and gender among the participants that was similar to the general Amish population, only one community was utilized.

Diabetes

To identify the susceptibility to the genes of Type 2 Diabetes, in the Amish community in the Lancaster area, Hsueh et al. (2000) recruited 953 adults with adult onset diabetes, which represented 45 multigenerational families. The Amish with diabetes tended to be older at onset, more obese, and have higher blood pressure and triglycerides than the nondiabetic Amish. Approximately 53% of these diabetics were on insulin. The researchers found the incidence of diabetes among the Amish to be 0.54 of the expected rate, which is much lower than the national average. Sibling diabetes was comparable to the national average. Standardized lab testing, strong community support, and the use of a 45 multigenerational families to show gene linkage strengthened this study.

Women's Health Care

Physicians and midwives who have worked among the Amish have provided most of what is known about pregnancy and childbearing in this cultural group (Armstrong & Feldman, 1986; Lemon, 2002). All babies are welcomed. Birth control is avoided, as it is considered to be tampering with God's will (Hostetler, 1980). Camparella, Korbin, and Achison (1993) examined patterns of prenatal health care utilization among 15 Amish women over a 10 week period. Utilizing participant observation, open ended interview, and structured interviews, the researchers discovered that the Amish women visit a physician to confirm their pregnancies and then seek health care with midwives or lay practitioners. Amish women are aware of potential problems related to pregnancy and do

desire competent care. First time mothers tended to start care at approximately four months unless extreme nausea and/or vomiting or bleeding was present causing them to seek earlier care. They also tend to deliver in the hospital. Women with multiple pregnancies tend to seek prenatal care later into their pregnancy, sometimes even in the third trimester, and deliver at home or in a midwife birthing center. The number one barrier to care was the inability to find a babysitter (40%) with 33% citing the long wait at the doctor's office. Only 20% of the women believed the physician cost was too high, which is in disagreement with Hostetler (1980), and 53% stated the cost was not a problem in general. However, this study supports Hostetler's findings (1980) that Amish view pregnancy as a private event and a normal and valued state. Childbearing is the means by which Amish women obtain status and are established in the community (Camparella, Korbin, & Achison, 1993; Hostetler, 1980). This study was limited by the small sample size, retrospective recall, self-report data, and the utilization of one Amish community. To date, no studies have explored the menopausal transition among Amish women.

Summary

The menopausal transition is a little understood, natural phase in a woman's life that generally begins around the age of 47.5 and lasts approximately 3.8 years. Symptomatology in the menopausal transition woman has been the main focus of research, with menstrual irregularity and amenorrhea the most worrisome symptoms. Other symptoms can be grouped into 2 categories: vasomotor and psychosomatic. Sexual problems are another concern, but little research has been done in this area. Current treatment for menopausal transition has been mostly extrapolated from menopausal women studies, with estrogen and HRT being the mainstay of therapy. Cross-culturally, women tend to agree that the menopausal transition is a natural phase, with little need for treatment or focus. Self-care measures are found to be effective for symptoms in most women. Women need more accurate and updated information at an earlier age to decrease frustration and allow for a better transition into menopause. Research needs include standard definitions for the menopausal transition, sequencing of symptoms, when and how to present menopausal transition information to the female and the

symptoms associated with menopausal transition and the best treatment options. Sexual health and quality of life issues are also lacking in the research literature.

Cultural studies are also scarce, with little known about the Amish women in particular. Little is known about how the Amish women approach the decline of childbearing in their lives, nor are we aware of the symptoms, if any, and how they are treated and the effectiveness of the treatment. With the unfortunate focus on illness in the American culture of menopausal transition, the Amish may be able to enrich our understanding of self-care measures.

CHAPTER THREE
METHODOLOGY

The purpose of this study was to describe the experience of menopausal transition in Amish women. An existential phenomenological design was used to discover the structure of this experience for the participants. The present chapter reviews the background information and characteristics of the design. The role of the researcher, data collection and recording methods, and the process of data analysis are discussed. Finally, issues of validity in qualitative research and reporting of findings are addressed.

Methodology

Qualitative research is a humanistic, systematic, subjective approach used to discover, explore, and describe the life experiences of individuals, while attempting to understand the individual as a whole (Burns & Groves, 1999; Madjar & Walton, 2001; Polit & Beck, 2004). Most qualitative research occurs in the natural setting of the participant allowing the researcher to develop an understanding of the individual in their world, while "creating awareness of idiosyncrasies and patterns in human behavior" (Madjar & Walton, 2001, p. 38). Nursing's focus on holistic care easily incorporates the qualitative method to allow for "exploring the depth, richness, and complexity inherent in phenomena" (Burns & Groves, 1999, p. 339). Qualitative research is an inductive method that is atheoretical, allowing the researcher to focus on the unfolding of the phenomenon rather than focusing on an expected outcome (Chinn & Kramer, 1999). The purpose of qualitative research is to gain an in-depth understanding of a phenomenon from a purposively selected group of participants. The qualitative researcher attempts to obtain rich, real, deep, and valid data from the participant (Polit & Beck, 2004; Porter, 1989). A major strength of the qualitative approach is the ability to "produce new and unexpected data, evidence we did not know was there" (Madjar & Walton, 2001, p. 41). Qualitative research is recommended for areas of research where little is known, and in-depth information about particular types of individuals is needed (Burns & Groves, 1999; Polit & Beck, 2004). Qualitative research may also have the ability to "provide important evidence of the cultural similarities and differences that make some therapeutic

interventions more or less appropriate for particular patients" (Madjar & Walton, 2001, p. 38).

Existential phenomenology, a form of qualitative research, is open, interpretive, and focuses on the meaning of the lived experience for the individual (Thomas & Pollio, 2002). This form of phenomenology allows us to explore the phenomenon from the perspective of the people in their world. The people are in the world, and it is in this world people learn about themselves (Merleau-Ponty, 1962). Existential phenomenology seeks to understand persons as being in a situation in which they (the persons) are in charge of determining themselves through their own choices as provided by the world (Merleau-Ponty, 1962). Phenomenology demands that our research evidence be "intuitable" or "that what is given or accepted as evidence must be actually experienceable within the limits of and related to the human experience" (Ihde, 1986, p. 21).

The main assumptions of phenomenology as described by Ihde (1986) are:

1. Any and all phenomena are open to investigation, but only as they are given to experience.
2. Phenomena are apodictic- "that which is present, is present in such a way that it shows itself as certainly present" (p.33).
3. Bracketing of ordinary belief, experience, and theory is essential in phenomenology.
4. Description of the phenomenon is more important than explanation. "Attend to the phenomena of experience as they appear" (p.34).
5. Horizontalization. All phenomena must be thought of as equally real.
6. All similar phenomena will have similar structural features.
7. Variations determine the limits of the phenomenon.

Existential phenomenology allows us to ask about the meaning of an experience. Data collection in done by using in-depth, unstructured, one-on-one interviews. The

initial question is usually posed in the form of "what" and is aimed at bringing about a description of the experience (Thomas & Pollio, 2002). The intent of the question is not to elicit a quick response, but to allow participants, the experts in the phenomenon, to describe their experience in all its richness and fullness by "directing the conversation to 'what you were aware of' in some specific situation" (p.24) or by asking "can you tell me about some incidents that stand out to you?" (Thomas & Pollio, 2002). The researcher then relies on the respondent's own words and phrases when asking follow-up questions, with the intent of gaining an experiential description of the phenomenon (Pollio et al., 1997).

All interviews are audiotape recorded and subsequently transcribed verbatim to create a text. Using hermeneutic analysis, a phenomenological research group is then utilized to examine at least some of the texts for the meaning units and to gain a sense of the overall structure of the phenomenon (Thomas & Pollio, 2002). Once this is accomplished, each interview is then related to all interviews and common patterns are identified (Pollio et al., 1997; Thomas & Pollio, 2002). Upon completion of the analysis, the global themes are identified and supported by the use of the respondent's own words (Thomas & Pollio, 2002). The research findings are then taken back to some of the study participants for review and verification of the study results. Finally, a report of the study is submitted to the research community (Thomas & Pollio, 2002).

The existential phenomenological approach was utilized for this research because I desired to describe the meaning of the menopausal transition in the world of Amish women. The ability to describe a phenomenon that cannot be observed is a major strength of this method. I also hoped to gain an in-depth understanding of the menopausal transition experience in this purposively selected group of participants as they experience this phenomenon in their world. A world that is different from mine but in need of study if culturally competent and holistic nursing is to be practiced. It is the responsibility of the health care provider to develop a mutually agreeable plan of care based on an understanding of the problem from the client's perspective and culture (American Nurses Association, 1991; Meleis, 1995). The Joint Commission of Health Care Organizations

has admonished us to consider each person's culture as it impacts his or her health care (JCAHO, 1994). As described above, phenomenology will allow me to examine the human experience of perimenopause in the world of the Amish women as they describe the phenomenon.

The Role of the Researcher

In any qualitative research design, the role of the researcher is significant. The researcher is the data collection instrument through whose interaction with the participant the data is collected. The researcher's main focus is to provide a context in which the participants freely describe their experiences in detail (Pollio et al., 1997). My ability to present myself as modest, trustworthy, honest, and open enhanced my usefulness in this context (Hostetler, 1980). I tried to listen with understanding and in a nonjudgmental way while being empathetically involved and without interruption of the narrative process.

Protection of Human Subjects

Prior to initiation of data collection, approval for the study was obtained from the University of Tennessee College of Nursing Human Subjects Review Committee and the University of Tennessee Institutional Review Board. Participants were asked if they were willing to participate in the present research study. Informed consent was obtained prior to the interview. Consent forms are archived at the University of Tennessee. Participants were informed that they might withdraw from the study at any time if they so desire without penalty. A copy of the consent form was given to each participant. All audiotapes were identified by code only. Only the primary investigator knows this code. All names of individuals, places, and any other identifying features were replaced by pseudonyms in the transcribed reports. The primary investigator transcribed all of the tapes. After the transcription of the tapes, all tapes were shredded. Transcripts are archived in a locked cabinet, in my office. Before any transcripts were presented to the phenomenology research groups, confidentiality statements were signed. These statements have been stored with the transcripts. Risk to the participants was minimal. There were no

unexplained or unexpected symptoms. However, referral to the participant's own medical provider would have occurred in the event of unexplained or unexpected symptoms.

Access to Participants

An intermediary, a man who resides in and is well known to the Amish community, was contacted to develop a list of women who might be interested in participating in the menopausal transition study. Each woman also provided a name of a friend who might desire to participate in the study. The women were provided with the question to be asked, the steps in the interview process, and assurances of confidentiality. The women were assured that the final results would be discussed with at least one participant to validate that their experience has been faithfully described.

The women were also assured the researcher in no way intends to disrupt the participant or community's way of life. The researcher only sought to obtain a description of the menopausal transition from the Amish women who were experiencing this transition to expand the knowledge that is already present in the literature about the menopausal transition. This knowledge will aid nurses and other health care providers to provide culturally competent care.

Bracketing Interview and Pilot Study

Prior to the interviews with the Amish women, another member of the research team interviewed me. Because of my work in women's health and menopausal transition status, I was asked the initial research question, which was to be used with the study participants. The bracketing interview was audio taped and transcribed by me, the researcher. The bracketing interview brought to the forefront my thoughts of how natural the transitional process was and the minimal impact the symptoms produced on my body. These realizations made me suspect that I may not have been as sympathetic with my menopausal transition clients who were experiencing problems as I could have been. The interview also made me very aware of the importance I placed on the relationships around me that were changing, which may not be an issue for other women. Following the bracketing interview, a pilot interview was done, transcribed, and presented to the phenomenology research group for thematic analysis. The pilot interview revealed four

themes: change-expected/unexpected, the natural/unnatural aspects of transition, validation of the experience by others, and the realization that the individual was growing older.

Data Collection and Recording

Study Participants

Participants in the study were a purposive sample of 10 women who identified themselves as experiencing menopausal transition. Final sample size was determined by saturation of the phenomenon, which manifested as redundancy of themes and patterns in the interviews. This redundancy often occurs after interviewing 3-5 participants (Pollio et al. 1997). Pollio et al. (1997) suggests interviewing 2 more participants at this point and if no new themes occur, there is no need for further interviews. Demographic data, including age, marital status, number of children, and menstrual pattern were asked of each participant before the interview was initiated. Criteria for entry into the study were that the woman must be Amish; age 44 – 52 (based on McKinlay et al.'s (1992) findings that revealed the median age of the menopausal transition is 47.5 $\pm$ 3.8 years); experiencing irregular menses or cycle changes; and have a willingness to talk about the experience of menopausal transition in her life. The women also had to be willing to have the researcher audiotape their interview.

Data Collection

In-depth, unstructured, one-on-one interviews were undertaken with each participant. The interviews were conducted in an understanding and nonjudgmental way, with no time limit. The interviews continued until no new information was obtained. In keeping with the principles of phenomenological data collection techniques, all women were asked the same opening question: "As you think of your experiences going through the 'change of life', what specific things stand out for you?" Triggers, such as "tell me more" or "go on", were used, if needed, to guide the women in describing their experiences, but direct questions to lead the interview in a particular direction were not used. Field notes were written after each interview to describe the setting, the participant,

and any other thoughts about the interview that came to me. Discussions with other Amish people, such as the midwife and bishop, were also included in the field notes.

Data Analysis and Interpretation

Analysis of data adhered to the format described by Thomas and Pollio (2002). The researcher transcribed all interviews. The researcher, to gain a general sense of the information present and the overall structure, then read each transcript. Several transcripts were presented to the phenomenology group for analysis and generation of meaning units and themes. Marginal notes were taken of all generated ideas. All transcripts were further analyzed for figural meaning units and themes, which were compiled and clustered to determine commonalities across transcripts and capture the emerging structure. Initial findings were reviewed with the research group for additional clustering and to ensure that the participants' words and experience were accurately represented in the results. After further refining, the structure of the experience was presented to the group for confirmation. After confirmation by the phenomenology research group, the structure was reviewed by one study participant to determine that the analysis accurately depicted the "essence" of the menopausal transition experience for Amish women.

Validation/Accuracy of Findings

In phenomenology, "validity means whether one has investigated what one wished to investigate" (Thomas & Pollio, 2002, p. 40). Validity is determined by the rigor and appropriateness of method, and how plausible and illuminating the findings are (Thomas & Pollio, 2002). The intent of the research is to "produce, clear, precise, and systematic descriptions of the meaning" (Polkinghome, 1989, p. 45) or essence of the phenomenon. Ultimately, validity is assessed by the reader, who examines the textual evidence to determine if adequate support, through the use of rich, thick description, was provided for the interpretation. The reader will judge if the participants' experience was reported in an unbiased manner (Pollio et al., 1997). Pollio et al., (1997) suggests that validity must be decided based on "whether a reader, adopting the world view articulated by the researcher, would be able to see textual evidence supporting the interpretation, and

whether the goal of providing a first-person understanding was attained" (p. 53). The review of the final report, by the participants, further validates the research findings if the participants are able to see their experience in the research findings.

Summary

This chapter has discussed qualitative research in general and then more specifically existential phenomenology as to the underlying assumptions and approach to research. The researcher's rationale for the choice of a phenomenological design as well as the role of the researcher in this process has been reviewed. Methods of data collection and recording were addressed, as were issues of validity. In the next chapter, findings will be presented.

CHAPTER FOUR

RESULTS

This study used phenomenological methodology to investigate the lived experience of the menopausal transition in Amish women. This method of inquiry allows for the development of a thematic structure describing the lived experience of the participants. The structure is derived from verbatim transcripts of interviews with Amish women who were experiencing the transition into menopause. As may be recalled, each participant was asked to respond to the following open-ended question: "As you think of your experiences going through the 'change of life,' what specific things stand out for you?" Further questions were asked only to clarify the participant's response to the initial question.

The description of each participant's experience was thematized using the methodology described in the previous chapter, and a thematic structure was developed as it emerged from the data. In this chapter, some brief demographic data describing the participants will be given. The thematic structure will then be presented and illustrated by samples of participant expression for each theme.

Demographic Characteristics

The ten participants in this study were Caucasian, Amish females who were experiencing menopausal transition. Their ages ranged from 46 to 52 years of age (average age at the time of interview was 50 years of age). All of the women were married to the same man of their youth. The number of children birthed by each participant ranged from 8 to 16, with an average number of 11 children. Five of the participants had experienced at least one miscarriage during their childbearing years. The majority of the women had their last child after the age of forty. Although experiencing menopausal transition, two of the women were pregnant at the time of interview. All of the participants lived in an Amish community. In the next section, the community is described.

The Setting

Tucked away from the hustle and bustle of city life is the Amish community. As I drove amidst the rolling hills and valleys on quiet country lanes bordered by pastures

containing curious cows and large well-kept yards that contained houses and red barns, I was forced to decrease my speed to match the black, enclosed buggy drawn by 2 shiny black horses that was ahead of me. A freckle-faced girl peeked out of the buggy at me from behind a large, black bonnet. A woman, dressed in a long, dark blue dress sat erect next to her, holding the reins of the horses. A young Amish boy of 10 or 11 streaked past us both on his roller blades.

Because of my decreased speed, I was able to truly observe my surroundings. The Amish settlement consisted of large, neat farmhouses surrounded by well-groomed yards, colorful flower gardens, and immaculate vegetable gardens and orchards. Almost every home had a variety of domestic farm animals and poultry, as well as dogs and cats. Beyond the houses were barns and sheds of various sizes that housed anything from animals to machinery and fields in varying degrees of readiness for harvest. Some fields were in the process of harvest through the effort of large, sweaty horses, pulling flatbed wagons and farm machinery, and bearded men and boys dressed in white shirts and dark pants held up by suspenders. Sprinkled throughout the community were a variety of businesses, a general store, several bakeries, and a large cabinet/furniture shop, schools, and fruit and vegetable stands. The community is also sprinkled with "English" (i.e., non-Amish) farmers. Their farms are obvious with large tractors working the fields, electric poles in the yard, and cars in the driveway.

Participant Vignettes

Betty

Betty is a 52 year-old woman who has experienced amenorrhea for 6 months. She is a mother to 14 children and has 24 grandchildren. She raises pedigree dogs, a variety of birds, and produce as sources of income. Betty's husband is a farmer. I interviewed Betty under 3 large weeping willow trees in her front lawn which overlooked a rippling stream and contented black and white cows chewing their cuds. Betty displayed a strong faith in God, which easily manifests in her everyday living.

Doris

Doris, a minister's wife, lives on a large dairy farm and raises vegetable and flower plants in her greenhouse, which she sells to area merchants. Doris is 52, has

experienced amenorrhea for 6 months, and suffers from polymyalgia rheumatica (PMR). She is the mother of 8 children and has 23 grandchildren. She was 44 with her last pregnancy, which ended in a spontaneous abortion. Doris was interviewed at her dining room table in a large, simple, clean home that spoke of friendliness and happiness. Her 2 daughters sang joyfully in the next room while they did the family laundry using a gas-powered wringer washing machine.

Kay

Kay, a 48 year-old diabetic who also suffers from hypothyroidism, was recruited at a greenhouse from which she was buying some plants for her garden. Kay is a mother to 9 children and has 1 grandchild. She has been experiencing lighter, shorter menstrual cycles as well as some hot flashes. I interviewed Kay on a grassy slope that overlooked an Amish farmer and his sons haying with horse drawn farm implements and wagons. Her 3 year-old son played a marble game in the dirt while we talked.

Sarah

A petite woman with sun-kissed face invited me into her almost immaculate home which overlooked well-manicured lawns and garden. Sarah is a 52 year-old homemaker and works in her husband's woodworking shop on an almost daily basis. She is the mother of 13 children, declares herself blessed with health, and has been experiencing lighter, shorter, and even missed cycles as well as hot flashes. Sarah invited me to sit on a delightful porch swing in her garden to be interviewed. The hummingbirds squeaked and fought amongst the hollyhocks as we talked.

June

June is a 49 year-old mother of 16, 11 of which are girls. Wanting to keep her daughters occupied, she became an entrepreneur of 3 thriving businesses; a candy store, a bakery, and a produce stand. I interviewed June in her large, country-style kitchen where I assisted her in picking over blackcaps while 2 of her daughters made blackcap jelly for the winter and a 3rd daughter balanced the books for the candy store.

Mary

Mary, a slightly overweight woman with a motherly face, invited me into her home with open arms. She simply stated she needed a break from the peaches she had

been canning all morning and would enjoy a good talk. Mary is 50 with 14 children. She suffers from depression and anxiety, a prolapsed bladder, and stomach problems. She has experienced 3 miscarriages during her childbearing years. Only within the last few months has she begun to experience hot flashes and menstrual irregularity. Mary was interviewed on a plush couch in her well-ventilated modest living room. A mixture of children and grandchildren played or worked in the yard as we talked. Her husband could be heard singing while he sewed canvas boat covers on his old treadle sewing machine.

Karen

Karen is a 52 year-old mother of 12 children. She suffered a stroke 2 years ago, due to a clot thrown by a defective mitral valve, with full recovery after enduring physical therapy for several months. Karen and her husband own and operate a thriving bakery with all mixing and kneading being done by hand. They now employ 6 other Amish women and men, and some weeks find they still cannot keep up with the orders. Karen very modestly admits to making the best donuts around! Karen's husband also runs a dairy farm. Karen experienced few irregular cycles and has amenorrhea now for 6 months. I interviewed Karen at her kitchen table over home brewed tea and pancakes.

Sally

Sally is an energetic, dark haired farmer's wife who is 46 years old. She is the mother of 14 children and is expecting her 15th child in 2 months. She has never experienced a spontaneous abortion and is aglow with this pregnancy. She was unaware that she was with child until she felt movement of the fetus, due to irregular menstrual cycles of approximately one year's duration. Sally was interviewed in her large kitchen/ dining room combination. Her husband, who farms, could be seen from the large picture window harnessing the horses as he and his sons prepared to finish the haying.

Faye

Faye is an energetic 48 year-old co-owner of a bakery. She has 10 children who range in age from 3 to 25. Faye was unaware she was pregnant with her last child until she felt the baby kick, due to irregular menstruation she had started experiencing a year or two previous to the pregnancy. In the past year she has begun to experience hot flashes. She also believes that she is pregnant now. Faye was interviewed in her spacious

living room where we could observe her younger children being pulled in their red cargo wagon by 2 "horses," their older brothers, who were on break from throwing hay into the haymow.

Sylvia

Sylvia is a thin, wiry, young appearing 52 year-old woman and the mother of 8 children. She raises fruit, mostly strawberries and raspberries, to supplement her farmer husband's income. Sylvia admits to arthritis, but believes all the fresh air and sunshine keeps her well. After picking my way through a manure-filled cow pasture, I interviewed Sylvia while picking raspberries in her large, immaculate garden.

Thematic Structure

The experience of the Amish women who is transitioning into menopause was contextualized by health and the reproductive body. Three themes emerged: "This is such a natural thing!" a descriptor of natural/unnatural; "I don't know if what I have has been normal, but what is normal?", a descriptor of change, the expected and unexpected; and "We finally figured it out," a descriptor of a search for clarification/validation. Each theme was interrelated, while being imposed on the background of health and the reproductive body. The schematic depiction of the transition and the interrelationships of the three themes are represented in Figure 4.1.

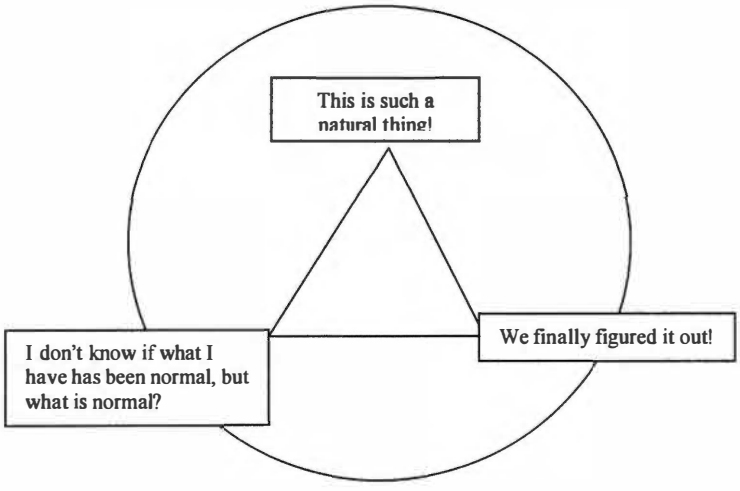


Figure 4.1 Thematic Structure:
The Experience of Amish Women Transitioning into Menopause

The following sections will describe the Amish women's experience of health and the reproductive body, which contextualize the three predominant themes of the menopausal transition.

Contextual Grounds for the Experience

"The biggest thing is my health"

For the Amish women, the menopausal transition must be viewed against a backdrop of health, the Amish view of health. When asked the research question, many of the women spoke of their general health, such as Kay who stated:

"I guess the biggest thing that stands out for me is my health."

Amish health is intertwined with their religion and the belief that all health is given by God. This belief is part of their everyday lived life, not just their religion. Most of the women believed themselves healthy. Betty expressed the thoughts of the women with the following statement:

> "The Lord has blessed me with just plain wonderful health. And as far as seeing a medical doctor, I plain just don't go."

Part of being healthy also included the ability to avoid medical doctors as expressed in the above statement. The Amish have a strong mistrust of "English" medicine due in part to their belief that the medical doctor is too busy to really care for them or get to the root of their problem. The Amish believe that listening and taking time with the person is also part of the healing process, something the medical doctor has not done in this community. Several of the women spoke of their resistance to "English" medicine. Karen reflected this resistance in her statement:

> "I guess I have kind of been fighting him (the medical doctor), since it is a drug, I would rather not. There are more natural ways."

The Amish bishop, who is Doris's husband, talked fondly of the two nurse midwives who have served the community for ten or more years. He believed the midwives listened and were willing to incorporate the alternative practices of the Amish, such as massage and herbal medications, into their nursing practice. The chiropractor was also a frequent manager of Amish health care. Chiropractors were perceived as willing to

listen; frequently scheduled follow-up visits; and prescribed adjustments, massage, and vitamins and herbal medications, all of which are acceptable to and natural for the Amish.

All of the women spoke to some degree about their use of vitamins, minerals, and herbs as a means to stay healthy, avoid "English" health care, and prevent problems later in their life. Most of the women were aware of osteoporosis and practiced preventive measures. June's words were representative of the views expressed by most of the women when she stated:

> "My husband and I both started early on to use supplements, vitamins, and minerals, and we still use them to this day, especially calcium. Keeps our bones healthy."

Sylvia also practiced prevention, but included herbs as a means of maintaining her health as shown by this statement.

> "I didn't need the doctor. We just really try to stay healthy. Herbs are very good to keep us healthy. We just really try to stay healthy."

Being healthy, for the Amish, includes the ability to work and maintain their activity levels. Without the luxury of modern conveniences, the Amish are dependent on their strength and ability to work. The women are responsible for running the household, which for most includes preparing and serving the meals and the growing and preserving of food to provide those meals, sewing and maintaining the clothes of their large families, and in many cases having another "career" as a source of added income. Several of the women admitted, despite their good health, to feeling their age more. June spoke for this group when she stated:

> "I still feel very healthy and keep up my work okay, but I do feel my age more lately. This (the menopausal transition) has been a healthy time for me. My family and I have always been healthy. We work and trust in God. This has been a healthy time."

There is also the expectation that with older age there may be a decline in work ability. Like many of the women, Betty knew she was no longer able to maintain the pace she did as a younger woman, but still believed herself healthy as shown by the following statement:

> "I am still able to work all day long going high speed at a lower rate. (laugh) I guess, not at the speed I did when I was young, but I have just been really healthy. You know, I really don't know what it is to be sick."

"Preparing my female organs." Embedded within the health practices of the Amish is a health care script for healthy Amish women. Girls are taught proper female care beginning with their first menstrual cycles. This script for care has been passed on for generations as shown by this statement of Betty's:

> "But one thing my mother, his mother, and my grandmothers always stressed is take...take real good care of yourself when you had your menstrual period and also after you had your baby. Proper female care is important. Well, mom always said not to have extremes. I couldn't go barefooted if it was extremely hot or cold or if I was going to work on cement. No running. No heavy lifting. Not extreme temperatures and not extreme exercising."

Betty has also implemented this advice with her own daughters, as have the other Amish women. Betty states:

> "When the girls had their menstrual period, then usually the boys emptied the pails, so they didn't lift too heavy. At school they weren't allowed to run and play, you know, play ball or something like that, just kind of light housework and easy work. Not real heavy or hard exercise."

The women also practice preventive care before, during, and after their pregnancies. The Amish midwife encourages all the women to incorporate vitamins and minerals, especially folic acid and calcium, into their diets before they ever consider having babies and to continue this practice through menopause. Karen spoke for the majority of the women when she stated:

> "I really kind of feel that (talking about nutrition) is a factor going through the change. You are not aware of it at the time. You are having babies and are busy and...but I know that it is important. I tell the girls now that if they are having or even thinking of having a child, be sure and take your vitamins and calcium. I really believe that is important. Probably even more important then we realize."

June summarized this preparation with her statement:

> "Oh, my transition was very easy. I have a book on menopause by John Harley. I began early on to prepare my female organs."

"All my births"

The menopausal transition must also be viewed against the woman's story of her reproductive body. There is a developmental process that starts with the women's first menstruation, progresses on through childbirth, and ultimately ends in menopause. A process of life review appears to facilitate the incorporation of the transition into menopause as a normal life event. To understand the story you have to hear about childbirth--the beginning. Childbirth is a prominent aspect of the story of her reproductive self/body. For many of the Amish women, this meant the birthing of healthy children without problems. Betty reflected this thought when she stated:

> "We had fourteen children, and I guess they are all healthy. We have 7 boys and 7 girls. And uhm, 8 are married and 6 live in another state and 2 are at home yet. And we have 24 grandchildren now. We have one set of twins. And I had one miscarriage…and I have had all the others since with no problem."

For others, the narrative included remembering the more difficult births also. Kay exemplified this idea when she stated:

> "That would have been my ninth and he was my tenth pregnancy…he wasn't the easiest, but he wasn't the biggest baby either. So, the first 5 children I had at home, I mean at the hospital. Then I had one at home and one almost at home."

The loss of the ability for natural childbirth was also important to remember. Betty stated:

> "All my births were normal until the last one and then for some reason (pause) nobody know why, the doctor doesn't even know why, we had to have it cesarean. But I guess that was for a purpose too."

And for a few, like Sylvia, the loss of her ability to have natural childbirth and eventually children needed to be explained to the interviewer. She stated:

> "I have 8 children. I was 32 when I had my last ones. I had to have a c-section with the last one and the twins before. He (the medical doctor) said I wouldn't be able to control my bowels anymore. I don't know how serious it was really. So I didn't dare go on with babies. It would not be good to go if you couldn't hold your bowels. I had a 10- pound baby once, and he thought that might have been part of the problem. He thought that might have damaged my muscles. So we stopped with 8 babies."

All of the women viewed the reproductive cycle as an ongoing event that may end for one generation of women, but the circle continues through their children and grandchildren. Betty found this to be true. She stated:

> "After I had the last one, and they told me I couldn't have anymore...so when this happened you thought, 'well, I have always loved babies, but there are still plenty of babies to hold, and I can take care of them and love them.' So my satisfaction and fulfillment comes from them."

Sarah echoed the same thought in her statement:

> "So there was change, but there was always more children. And once your own are all grown, you have the grandchildren. There are always children. They keep you young."

As shown in Sarah's words, many of the women viewed the children, the results of their reproductive cycle, as a fountain of youth. The numerical age of a woman was not as good an indicator of age for the Amish as was the number of children who were in school or preschool. As indicated by Sarah, the children are what kept the women young. Karen saw herself as young, despite a married daughter, because she still had a small child at home. She stated:

> "But I stay young. My oldest daughter had been married 2 years before I had my youngest."

Sally agreed. She stated:

> "Our youngest child was 7 already when she (the baby) came along, so it was like, we thought we were already getting kind of old. Our children were old and all of a sudden we were parents again of a little child. It puts you in a younger category again. So it almost makes you feel younger again."

Themes

The contextual ground of Amish health and the reproductive body served as a framework for understanding the thematic aspects of the menopausal transition. Within this context, three themes stood out as distinctive: (1) "This is such a natural thing!" exploring natural/unnatural, (2) "I don't know if what I have has been normal, but what is normal?" a descriptor of change: the expected/unexpected, and (3) "We finally figured it out," which focuses on the women's attempts at clarification/validation of the transition.

The verbatim words of the women were used to title the themes. This section will discuss each theme.

"This is such a natural thing!": Natural/Unnatural

The Amish women view the menopausal transition as a natural time, part of the natural progression of their reproductive life. It is as much a part of their life as bearing children has been. Their mothers experienced the transition, they know they are experiencing it, and their daughters after them will also experience it. As Faye stated:

> "This is such a natural thing. It is just like everyone else, you have to go through that and it will quit at some time. It is just one of the things I figure you have to go through it."

Since the transition into menopause was considered a natural part of their life, most of the women were able to continue with their daily duties and gave little thought to the changes occurring in their bodies. Kay reflected this when she stated:

> "Well, when you're not worried about something, it doesn't cause as much trouble. If you don't make stress (laugh) you don't have to worry."

June added:

> "If you are working hard, you don't have time to worry about things like menopause."

Since this transitional period is experienced as natural, natural measures are preferred to maintain the women through this transition. Work, vitamins, minerals, and herbs, and trust in Divine Power were the preferred treatments. Betty summarized this for the women when she stated:

> "I use vitamins and minerals and herbs and you know, things like that. Try to stay as healthy and natural as we could. I wasn't organic naturally, but I was just something like that. We lived on the farm and had our own milk and eggs and things like that, you know. Vegetables. Meat."

Kay further elaborated about trust in God. She stated:

> "When you put your trust in Him, you have some one to lean on and trust when it gets rough. That is basically the help. When I get to a desperation stage of too much anxiety, then I just let Him take care of it. It is a natural thing. I have just always relied on Him and He has come through."

Several of the women did admit that certain aspects of the transition had caused them to question the effectiveness of their treatment and to seek outside help from the medical world. However, all the women agreed that the measures the "English" doctors prescribed weren't helpful and discontinued them not long after seeking treatment. Karen reflected this idea with her statement:

> "Doctors aren't very helpful when it comes to these things. They don't have a lot for you unless you want to go on more pills. I don't want to do things that are unnatural. This is such a natural thing."

Mary, as several other women did, tried pills, but went back to the natural. She stated:

> "I was on estrogen for awhile, but I kind of got scared of that. I quit that and tried to use other things, but you have to keep in mind that I am trying to doctor with natural herbs and things. Everything natural."

"I don't know if what I have has been normal, but what is normal?" Change: Expected/Uunexpected

All of the women expected changes to occur with their bodies as they transitioned into menopause. Some changes were unexpected, however, and caused the women to wonder if their experience was "normal." Several women contrasted their experience with the transition of other women in their families. Kay expressed this thought in her statement:

> "I know menopause is different for each person. My mother-in-law, well I guess it has only been recently she hasn't had problems. But she had real bad hot flashes and all those nasty side effects and it took her a long time, at least 10 years, to get over this business. On my side of the family, it seems to be a quick something. My grandmother had it quick."

Several of the women believed that the transition could be no worse then the menstrual cycle problems that they had experienced. Kay, who suffered from premenstrual syndrome every month, made the following statement:

> "Yes, I just sort of bear through it (transition symptoms). It was my doctor's recommendation, if I can bear through it, the side effects (of medication) are worse, usually, than the problem."

However, many of the women were uncertain about how these changes would manifest themselves in their own body. Such as Karen who stated:

> "I don't know if what I have has been normal, but what is normal? I am sure there are others who are more normal."

For many of the women, the changes that occurred in their bodies (i.e., hot flashes, menstrual irregularity and other changes such as sexual dysfunction) were either much more intense then they had expected or totally absent. For some women, the unexpected was the hardest to deal with. Mary summarized this thought with the following statement:

> "It's just the mood swings, the sex life, and the hot flashes. The things that come with it, they have been the hardest to deal with."

In the following sections, sub themes will be discussed. Women's words elaborate on various facets of the expected and unexpected changes that they were dealing with during the menopausal transition.

Hot flashes. Whether the women experienced hot flashes or not, most of them expected to have hot flashes. However, the hot flashes appeared to be as individualized as the women who experienced them. Most of the women experienced hot flashes to varying degrees of annoyance. June who experienced hot flashes at night, found them to be the worst part of the transition. She stated:

> "For me, the worst thing has been hot flashes at night. I get so hot in the middle of the night that I feel like I could tear off my sleeping gown. I felt like there was a lack of oxygen. I needed a fan. The hot flashes, they were probably the worst."

Doris had a similar experience with hot flashes as shown by the following statement.

> "I would wake up at night and I was sweaty all over and sometimes I was hot and sometimes I was cold. I mean, it was just…there was only, really a few years the hot flashes were bad and then I got over them. I had a lot of times where I would wake up at night where I couldn't sleep and stuff like that going through the change."

Unlike June and Doris, Sylvia experienced such mild hot flashes that she was not even certain she was experiencing them. She stated:

> "Sometimes they say you go through heat flashes or something like that. I don't know if I do or not, but sometimes I'm warm or I sweat, but not serious. Nothing real serious. Nothing to worry about."

And Faye, although hot flashes disturbed her sleep, found ways to cope with them including laughter as shown by the following statement.

> "I did have hot flashes till I started taking those pills (3 herbs). I did have hot flashes a long time ago. Now I just get them off and on. Those bother me most at night. I was kind of warm and no body else was and I couldn't figure out why and...Oh yeah. But uhm, I think maybe my time is...the night time is...you just have to get your covers off and (laugh) cool off again."

Although most of the women, like Betty, expected to have hot flashes some didn't. Betty said:

"I didn't have hot flashes. I didn't have (pause) I don't know what it is all about really."

Irregularity. The women also expected menstrual cycle changes. Despite the lack of regularity they had experienced through their childbearing years, the irregularity associated with the transition was annoying. Faye stated:

> "I guess I would have to say not knowing when it's (referring to periods) going to start. Like last week was that week and I didn't start with it yet. But sometimes it goes five weeks. Sometime six weeks. But it has been three or four weeks too."

Sylvia agreed:

> "I guess I would have to say my menstrual cycle has changed. They are not as regular. Sometimes they are real light and sometimes normal. Its kind of... more like, the last six months have been irregular and black like."

For other women, the discomfort they experienced with premenstrual symptoms followed by a missed cycle was frustrating as shown by the statement from Sarah referring to her menstrual cycle:

> "Every 4 weeks and sometimes every 3 weeks and about 3-4 days. It was different from before. It usually was every 5-6 days. And some months I feel like I am going to get it. (period) I get all bloated and headachy, but it doesn't come."

For some of the women, the change was so drastic, they felt like their body was unruly and causing them more stress then necessary. Sally stated:

> "Cycle problems? No. I just didn't get them as heavy as I should at one time. It just made me feel like, when it was time for my cycle. It just made me feel like pulling my hair out of my head. Your body wanted to, was trying to perform, but it couldn't. And it just made you feel like you could go to pieces."

Many women experienced a change in the character or flow of their period along with the irregularity, which was unexpected. Kay stated:

> "I had a mini-period, which was for me, unheard of. I always had heavy periods. Say 3 days that were really heavy and then it would last 8 days more....So to have just a little bit of spotting for 1 day was...and then the next one was 10 days early. And the third was 5 days early, but everything else has been pretty much on schedule."

While Kay's statement reflected the women with lighter flow, other women, like Sue, started experiencing heavier flow. She stated:

> "I started having some heavier periods the last couple of times. They were heavier then they used to be."

"Except this one problem." In addition to hot flashes and menstrual irregularity, several women voiced concern about their ability to respond sexually and of lost desire. Intimacy issues affected not only the women, but their husbands as well. For some women, such as Mary and Sally, the frustration was evident as shown by their statements:

> "Except this one problem that...it was bad before surgery, but after I had surgery...it was kind of a problem (fades away) Now, it's just, but I just don't care for it. For me I would just give it up and forget it. But men aren't that way. So we have tried...co-operating; (pause) there is just no urge at all. Like, just no urge at all."

> "If you have female problems, if you don't understand what's happening and you have those problems, it might make you feel like you don't want your husband to touch you. It just gives you a feeling that is not very nice. You don't have the desire like a normal woman would."

Several of the women began experiencing health problems during this time frame. So, while the women knew the hot flashes and menstrual irregularity would end, their health issues would continue, such as Doris, who stated:

> "There was only, really, a few years the hot flashes were really bad, and then I got over them. But I am still on medication for my PMR."

For other women the physical symptoms were not as much of a problem as the depression and psychosocial issues the women found themselves dealing with. The women expressed the idea they were healthy and able to work, but the psychosocial

issues were wearing them down. For some, like Faye, the situation seemed to cause a momentary shut down.

> "All at once it just kind of...seems like the...the wire is cut off. I can't, in my head, and I can't do anything. I can hear and I can see, but I can't, I can't understand the people. It just lasts a minute or so."

Karen states:

> "I have found it very frustrating, and that doesn't help my anxiety any either. It is because it's not...it's never something physically; I am working harder then ever one day."

And despite their best efforts, they remained frustrated and tired as shown by Mary's statement:

> "I am still tired. I am on multivitamins and different things like that and uhm, lots of vitamins. I don't know if it's the stress that keeps me run down or...I just don't know.

Many of the women were anxious about their children. For some of the women, distance or health issues were at the root of the problem. While other women were concerned their children would no longer follow their faith. Kay stated:

> "Well, we have also had a rebellious teenager, so...she has been enough to keep anyone from thinking about anything else. We are quite concerned that our children, that they stay with the faith. If they don't want to, that is stressful."

Several of the women admitted to moving beyond anxiety and frustration into depression. The depression was many times related to family issues. Mary stated:

> "Depression. You know, you just don't care to live. You know, it's kind of like...you have to go on. Stress. Family problems, too. We've got a son that uhm. He has a node. It was cancer. And now, it seems like it is coming back. And then we had a son that didn't (pause) he pulled away. He left his wife. He left his faith and (pause) he isn't with, he has, he has nine children. And that almost, that was a lot of stress. A lot of stress, too. Besides, it is just part of the whole change."

Karen expressed the thoughts of many of the women who were feeling anxious, frustrated, and depressed.

> "You know my cycle was heavier. I was just tired. I never expected it. You know, if you have had children and lived through that, the rest would be easy sailing from now on. I guess it is for some people."

"I was really kind of looking forward to..." A final sub theme was the loss of the expected or unfulfilled expectations. Many of the women expressed the thought that they had looked forward to this time in their lives. They entered this transition with the belief that they might begin to slow down and enjoy the fruits of their labors, take up hobbies and other interests, and enjoy their families and perhaps what their families could now offer them. Mary expressed this thought in the following statement:

> "I was really kind of looking forward to…you know, getting older, mature, grown-up. You can share in your children. Grandchildren. They would share and help. I would have more time…I like to sculpt."

But Mary also mirrored many of the women's frustration.

> "But I have been able to do very little of that. I am always running from one task to the next. It just keeps me wore down. Depressed. That is hard."

Most of the women also expressed the idea that their life had remained pretty much the same. Work continued as before, despite the fact that the believed they were at the point in their lives where they should be able to slow down. Sarah reflects this in her statement:

> "It (the menopausal transition) wasn't anything real different. There was always work to do. You just had to adjust to the family as everyone gets married. The work never ended. There was not really anything different. I had to stay busy with the gardening and canning and the children. I didn't have time to worry about it (going into menopause). You have to keep up with the housecleaning. Sometimes you were really tired, but you just didn't have time to sit down."

Several of the women also expressed the hope that the "next week would be better" only to have those hopes dashed week after week. Again, Mary summed up their thoughts well with the following statement:

> "I have peaches on my mind. I had cherries to can last week. And I have three grandchildren here. They help a lot, but still its still kind of…you have to make sure everyone gets something to eat. I had to keep the dishes washed and the floors swept, but I would like to sit down and sew. But I don't get it done. I don't have the time. Each week something new comes up. There is always something extra on my mind. You think, 'next week it should go better' and next week comes and something comes up."

Karen concluded:

> "It just seems like, uhm, I feel like I have to much work. I can't enjoy it. And I use to enjoy it, but I have to do so many things to keep up with daily living. And, so, I am just trying to do the best that I can."

"We finally figured it out.":Clarification/Validation

The women expressed a need to clarify and understand their experience of the menopausal transition and validate that experience. For some women, who had experienced few symptoms or changes or given little thought to the transition, the need was only to validate that they were entering menopause. For those women who had experienced a variety of physiological and psychological changes, more clarification and validation was necessary. This clarification and validation is described in the next sections. The theme, "We finally figured it out" contains three sub themes: "It has to be hormonal", "Talking with others", and "Studying on my own".

"It has to be hormonal." Many of the women attempted to explain physiological and psychological changes as hormonal. For example, some women tried to draw a connection between physical symptoms and hormones. Karen stated:

> "Well,… and I will have nothing as far as feeling poorly. And then the next day might just be the opposite and everything is all messed up. So it has to be hormonal. It has to be. I do read about this topic. I probably should spend more time with it so I can understand it better. And then I could understand better, maybe, what is going on with me."

Karen also reported a significant increase in mood swings and depression since her transition into menopause, which she attributed to hormonal changes. Karen stated:

> "Depression. Depression goes with it too, the…the change. I wonder if it doesn't all go with the menopause. I believe that, I know it goes with it too, the…the change."

Changes in health status were also linked to the transition. Many of the women believed any decline in their health status was directly related to the transition into menopause. Karen and Doris both suffered from health problems. Karen stated:

> "I think all my problems started when I began going through the change of life. I am not sure that it is all from that, but… They determined the stroke was caused from a hole in the heart. It was never a problem till the change."

And Doris related her problems with PMR to the change.

> "It was right at the time, about 6 years ago, when I started going through the change that I was diagnosed with PMR. I started with that right at that time. I kind of felt like it was because I had started going through the change."

Mary blamed the transition for her problems with stress and depression as shown by the following statement:

> "I could tell it was more stressful once I started going through my change. A lot of things bothered me more."

Even family issues were related to the transition into menopause by many of the women. Kay stated:

> "We try to have close ties with our children, and if they have problems we try to work it out, but still…it has been stressful and I guess that has all occurred while going through the change."

Other women were misinformed about their own anatomy and physiology, which only added to their confusion about their health and the uncertainty of the menopausal transition. Sylvia and Sally were two such women. Sylvia stated:

"My health isn't what it could be and my uterus keeps tipping. I am not sure, you know, what causes that. It was out of place for a long time, and maybe it is just weak still. And I also have a problem with a bone in my back that connects with the female organs and I thought maybe that has something to do with it too."

While Sally believed the transition was to blame for many of her health problems, she was ignorant about her own anatomy. She stated:

"I am not sure when it happened, but apparently sometime during childbirth with one of my last children, a bone went out of place on the inside and twisted my muscles and my female organs were all messed up. I didn't realize. I guess I didn't think much about it, that my health was failing. I didn't know what was the cause."

Many of the women began to actively seek information to clarify and validate this transition in their life. They attempted to explain their doubts and confusion through three means: seeking information from their mothers and other female relatives, others inside and outside the community, and studying on their own.

"I asked my mother." Some of the women recalled that their own mothers had very little difficulty during this transition. Kay made the following statement about her mother.

> "My mother went through it (the transition) and it was a breeze. My grandmother passed away and that was it. She had a monthly before and never after. No side effects of any kind."

However, other women had very little information about this time period as the subject was off limits for the previous generation. Kay further explained:

> "My great aunt, I don't know if she ever stopped. It was not something you talk about with people of that generation. And you don't talk about it anyway."

Mary also found the subject taboo in her family, but believes many of the problems that she experienced could be explained by the change. Mary stated:

> "When I was growing up, you just never heard people talking about menopause. Never mind what they were going through. I, mother never talked to me about it, but as we look back and think about some of the things she done, we feel that was her change."

Other mothers had babies through the transition phase and had little information to give.

> "I asked my mother if she ever had anything like this during her time, but she had babies through her time."

For other study participants, the talks with their mothers did not clarify or validate their experience, because their transition was so different from their mothers'. Such was the case of Betty who experienced little of what she expected, but remembered her mother's experience as terrible.

"And another lady told me..." Many of the women did seek information from sources outside their community. Several women discussed the transition with other women who were neighbors or friends, again with varying degrees of success. Faye, like several of the women, found their own transition was easier. Faye stated:

> "Talking with others, mine has been easier. Mine is easy compared to the lady down the road. She's having major problems."

Karen spoke with an "English" neighbor and received no clarification or validation. She was still confused as shown by her statement:

> "I hope you just have it (menopausal transition) for a season, but I have had people tell me, 'Oh, I had it for 5 years.' And another lady told me it was 10 years for her. But I don't know what they mean by that. Do they mean that they have all the symptoms that you might have all the time or just a few?"

Several sought out information about their health problems from the medical community with varying degrees of success. Some women believed they were only given a label, but no information about the label. Mary found this to be true and summarized this thought for the women when she stated:

> "So I kind of went to the doctor, the medicine doctor, and he did a pap smear and he put me on estrogen. But you know, after I tried everything…I would still get these hot flashes and night sweats."

Many of the women sought out their chiropractors for clarification and/or validation. Sally was one such woman. She stated:

> "So that (going to the chiropractor) helped me to understand why I was feeling the way that I was. It came from a physical problem. And I understand myself better because I don't have to think I don't love him because I feel this way. It is a physical problem that is causing it."

Even though the women might receive wrong information from the chiropractor, they believed they were given more information than they had received from a medical doctor.

Studying on my own. Many of the women spoke of books that were recommended to them by the nurse midwives and their own Amish midwife as a means by which they learned about menopause and transitioning into menopause. Karen exemplified this when she began studying for herself as shown by her statement:

> "It was all very new to us. We finally figured it out. I mean, they (the medical community) didn't really tell us. I read mostly from my herbal book about it (menopause), but I did read something in *Good Housekeeping* when I was in the doctor's office. Mostly though, from the herbal book. One we got from the library about herbs and things had some real good information. That book was very good. I shouldn't say this to you since you are a nurse, but doctors aren't very helpful when it comes to these things."

Like Karen, many of the women did receive clarification of the things they were experiencing and validation of their symptoms through study of their own.

Summary

The thematic structure of the experience of transitioning into menopause is described in relation to Amish view of health along with their healthcare script and perception of the reproductive body. Health is seen as the ability to avoid medical doctors and the ability to work. The reproductive body begins with the first menstrual cycle and never really ends with menopause, because of the children and grandchildren, which give the women continued youth and vitality. Three themes emerged about the menopausal transition: "This is such a natural thing!" a descriptor of natural/unnatural; "I don't know if what I have has been normal, but what is normal?" a descriptor of change, the expected and unexpected; and "We finally figured it out," a descriptor of a search for clarification/validation. The themes that form the structure are intertwined and interrelated. As described by the participants, the menopausal transition is a natural event with expected bodily changes that is distinctly different for each individual woman. For some women, unexpected changes caused questions to surface about their normalcy, requiring further clarification and validation. Discussion of the findings will be presented in Chapter five.

CHAPTER FIVE
DISCUSSION

The purpose of this study was to describe the transition into menopause as experienced by Amish women. Interviews were completed with ten women using the existential phenomenological approach described by Thomas and Pollio (2002). Verbatim transcripts of the interview recordings were interpreted both by the researcher and an interdisciplinary phenomenological research group. The results of this analysis revealed a thematic structure for the experience of being an Amish woman transitioning into menopause. Themes all emerged against a ground of the reproductive self/body and health. From this ground the figural aspects of the experience were described in terms of: natural/unnatural, change-expected/unexpected, and clarification/validation. This chapter will discuss this thematic structure and its implications for nursing practice, education, and research.

Thematic Structure

The experience of menopausal transition as described in the present study must be viewed against the contextual background of Amish health and the Amish women's reproductive bodies. Health is an important component of Amish life as health is equated with the ability to work hard (Armer & Radina, 2002) and maintain their life in the community. Health, for many of the women, was also defined as the ability to avoid medical doctors. However, the Amish women, like other cultural groups (Canparella, Korbin, & Achison, 1993; Longworth, 2003; Tsao, 2002), do not reject medical technology, but select those medical treatments that are congruent with their way of life. The women from this study did express preference for and the increased use and trust of chiropractors and nurse practitioners over the medical doctor. Health promotion behaviors such as the abundant use of vitamins and minerals, nutrition, and specific guidelines for reproductive health are widely followed and passed on from generation to generation which supported previous research findings (Hostetler, 1980; Levinson et al., 1989). Menopause, for the Amish, is viewed as part of the reproductive cycle and is therefore considered part of the natural order of life.

As was the case with most of the women in both mainstream American culture and other cultural studies (Berg & Lipson, 1999; Bueche & Gelser, 1997; Carolan, 2000; Chaiphibalsarisdi, 1990; Chang & Chang, 1996; Hautman, 1996; Im & Meleis, 2000; Longworth, 2003; Palmer et al., 2003; Tsao, 2002) the Amish women concluded that transitioning into menopause was a natural event and did not constitute a need, for most of the women, to significantly change any aspect of their life. Unlike their American counterparts who viewed transition as a time to begin preventive practices to guard against diseases, such as osteoporosis and heart disease (Woods & Mitchell, 1997), the Amish women began preventive health measures early on while still in their youth. Exercise, in the form of hard work, is a daily experience for most of the women.

Unlike some of the women from previous studies (Anderson & Posner, 2002; Carolan, 2000; Woods & Mitchell1997), the Amish do not view menopause as an escape from childbearing or a sign that they are aging. Babies are a key to the fountain of youth and welcomed. Many of the Amish women interviewed had experienced childbirth after the age of 40, and expressed the belief that these young children maintained their youthfulness. Their children and grandchildren were their source of happiness and fulfillment. Their families were their mainstay and support, which lends support to Hosteller (1980) who found that the Amish family's purpose was for procreation, nurturing, and the socialization of children.

The Amish women experienced transitional symptoms that can be placed on a continuum from none to a large variety, supporting the premise that the experience of transition is a highly personal event and must be understood within the framework of each woman's culture (Bueche & Gelser, 1997). As with other women, (Kittel et al., 1998; Li & Holm, 2000; Li, Holm, Gulanick, Lanuza, & Penckofer, 1999; McKinlay et al. 1992; Schott-Baer & Kotal, 2000) menstrual irregularity and change in character of menstrual flow was a common complaint among the Amish women despite the lack of regularity during the childbearing years. Hot flashes were an expected part of the transition whether they were experienced or not, and like the women of McKinlay et al.'s study (1992), the hot flashes had the potential to disturb sleep.

Amish women also experienced their share of psychosocial disruptions, decline in health, and depression. Women who described problems with depression and anxiety were more likely to relate a decline in their health status, problems with teenagers or adult children, and/or previous inability to handle stress, while women who expressed a high level of well-being, a positive attitude towards menopause, and ability to accomplish work were less likely to have experienced depression during their menopausal transition. This finding is consistent with the research of Van Hall et al. (1994) who found that psychosocial factors were more likely the cause of distress in midlife women; Avis (2003) and Woods and Mitchell (1997b) who concluded that depression is more the result of health status than menopausal transition; and McQuaide (1998) who discovered that high levels of well-being were related to high levels of health. Unlike the women of McQuaide's study whose well-being had nothing to do with the number of children in the home, the Amish women did express a higher degree of health and well-being if their children were still in the home. These findings support the earlier findings of Jaszmann et al. (1969) who found women who had children in their forties had higher levels of well-being. In contrast to research of the 1970's on "empty nest syndrome", Amish women do not experience depression as the result of the "empty nest syndrome" (Crawford & Hooper, 1973; Van Keep & Kellerhals, 1974). Their nest is not empty.

Like their Korean counterparts (Im & Meleis, 2000), the daily demands of their lives require the Amish women to fulfill a variety of roles. The responsibility of everyday life consumes all their time and energy. Most of the women expressed the thought that the transition into menopause had changed little in their daily lives, although they would like to be able to slow down, have some time for and focus their energies on themselves. They were disappointed when they realized this was not a possibility. The gardening, cooking, cleaning, sewing, and childcare would continue. Like the Korean immigrants, this lack of time and energy for ruminating may in part explain the relative ease with which the Amish women were able to normalize their menopause.

The Amish women, like women from other studies (Huffman & Myers, 1999), believe that one of the worst aspects of the transitional phase is the lack of concrete information and the uncertainty that surrounds the transition into menopause. Many of

the Amish women sought validation and clarification from within their families- especially their mothers, neighbors and friends, and literature and books. Others sought to explain the changes they were experiencing as hormonal.

Another way the Amish women differ from mainstream American culture is the lack of discussion or concern for their physical appearance. In a society where mainstream magazines are full of ads for wrinkle creams, Botox injections, and face lifts, the Amish women seemed to have little concern about their appearance or aging. Their obvious lack of concern over aging or appearance mirrored the African American women of Sampselle et al.'s study (2002), who were in sharp contrast to their Caucasian counterparts and gave little thought to their physical appearance.

Implications for Nursing

Nursing Practice

The Amish are a health-minded people who rely heavily on self-care measures and prevention. The practitioner working with transitional Amish women must be willing to include alternative therapy and homeopathic medications that are tailored to each woman's reality, while including additional information about the natural aspects of transitioning, self-care and self-management strategies. Prevention of osteoporosis, diabetes, cardiac disease and hypertension should be emphasized at each visit long before the transitional phase of life.

Nursing needs to recognize and appreciate the uniqueness of the menopausal event for each woman. The deliverance of quality care to Amish women will be enhanced by the extent to which nursing is able to understand the women's transitional experience and the meanings they attach to these experiences. Nurses need to give Amish women the opportunity to review past events as they relate to the transition, to connect with their mothers' experiences, and to consider what is happening physically and emotionally at the present.

Health care providers need to listen with a caring, empathetic attitude as we seek to share in and validate their experience of transitioning. Perhaps, the care provider should more closely model the chiropractor that the Amish perceive as a listening, compassionate provider who has time to listen and allows and even validates the use of

homeopathic medicine. Follow-up visits may also increase the woman's trust in the healthcare provider patient relationship, since the visit would be perceived as caring.

There is the need to bridge the gap between a woman's need to understand her body, the changes occurring in her body, and the information available to assist with that understanding. The health care provider should become aware of the literature currently used and recommended within the Amish community. Nurses must ensure that their clients have accurate information about their own anatomy and physiology. Nurses must then educate their clients about the menopausal transition by providing accurate, unbiased information that is representative of the complex nature of transitioning into menopause. By listening to their clients, the health care provider can gain insight into how they perceive and respond to change during transition and correct any misconceptions and misinformation.

Nursing Education

The transition into natural menopause is a fairly benign event for most Amish women. As with other cultural groups, psychosocial and health issues may be more important than the transition itself. Nursing students must be taught to view the client holistically and seek to be aware of all factors that could positively or negatively affect the transitioning woman. Educators should include within their curriculum information about alternative therapy and homeopathic medications that may be used by women during transition, and the potential benefits and side effects of these methods.

Nursing Research

Findings of this research contribute to a phenomenological understanding of the human body by reminding us that the body is more than an object. For each of the women in this study, the menopausal transition was a unique experience that was replete with meaning for the group as a whole, but also at the individual, "my body" level. Through phenomenological inquiry, the women's bodily experience of transitioning was allowed to take form and shape.

This study makes a contribution to the research literature because the experience of menopausal transition among Amish women has not been previously described. In addition, this study contributes to the body of knowledge about the cultural aspects of this

phenomenon. Phenomenological inquiry allowed for the expression of the importance of exploring the menopausal transition within the context of Amish culture. Further research among the Amish women should explore the impact of later life pregnancy on transitional symptoms, the average age of menopause, and the occurrence, severity, and usual treatment of transitional symptoms. Research needs to further explore and give meaning to the concept of menopausal transition in all cultural groups and how these concepts relate to attitudes about the transition and menopause while allowing for the uniqueness this transition represents for each midlife woman.

List of References and Bibliography

References

Aber, C. S., Arathuzik, D., & Righter, A. R. (1998). Women's perceptions and concerns about menopause. *Clinical Excellence for Nurse Practitioners: The International Journal of NPACE, 2*(4), 232-238.

American Nurses Association. (1991). *Position Statement on Cultural Diversity in Nursing Practice.* Washington, D. C. : American Nurses Association.

Anderson, D., & Posner, N. (2002). Relationship between psychosocial factors and health behaviours for women experiencing menopause. *International Journal of Nursing Practice, 8,* 265-273.

Andreoli, E., & Miller, J. (1998). Aging in the Amish community. *Nursing Connection,* 11(3), 5-11.

Andrist, L. C. (1998). The impact of media attention, family history, politics and maturation on women's decisions. *Health Care for Women International, 19* (3), 243-261.

Armer, J., & Radina, M. (2002). Definition of health and health promotion behaviors among Midwestern Old Order Amish Families. *The Journal of Multicultural Nursing and Health, 8*(3), 43-52.

Armstrong, P., & Feldman, S. (1986). *A Midwife's Story.* New York: Arbor House.

Avis, N. (2003). Depression during the menopausal transition. *Psychology of Women Quarterly, 27,* 91- 100.

Bassett, D., Schneider, P., & Huntington, G. (2004). Physical Activity in an Old Order Amish community. *Medicine and Science in Sports and Exercise, 36*(1), 79-85.

Berg, J. A., & Lipson, J. G. (1999). Information sources, menopause beliefs, and health complaints of midlife Filipinas. *Health Care for Women International, 20*(1), 81-92.

Bilitski, J. (1981). Nursing science and the laws of health: The test of substance as a step in the process of theory development. *Advances in Nursing Science, 4*(1), 15-29.

Bromberger, J., Meyer, P., Kravitz, H., Sommer, B., Cordal, A., Powell, L., et al. (2001). Psychological distress and natural menopause: a multiethnic community study. *The American Journal of Public Health, 91*(9), 1435-1442.

Bueche, M. N., & Gelser, L. J. (1997). Women's lived experience of perimenopause. *Clinical Excellence for Nurse Practitioners: The International Journal of NPACE, 1*(7), 437-443.

Burns, N., & Grove, S. (1999). *Understanding Nursing Research* (2nd ed.). Philadelphia: W.B. Saunders.

Busch, C. M., & Zonderman, A. B. (1994). Menopausal transition and psychological distress in a nationally representative sample: Is menopause associated with psychological distress? *Journal of Aging and Health, 6*(2), 209-229.

Campanella, K., Korbin, J., & Acheson, L. (1993). Pregnancy and childbirth among the Amish. *Social Science Medicine, 36*(3), 333-342.

Carolan, M. (2000). Menopause: Irish women's voices. *Journal of Obstetric Gynecologic and Neonatal Nursing, 29*(4), 397-404.

Chaiphibalsarisdi, P. (1990). Self-care responses of rural Thai perimenopausal women. ([Abstract] Doctoral dissertation, University of Illinois at Chicago, 1990).

Chang, C., & Chang, C. H. (1996). Menopause and hormone using experiences of Chinese women in Taiwan. *Health Care for Women International, 17*(4), 307-318.

Chinn, P., & Kramer, M. (1999). *Theory and Nursing Integrated Knowledge Development* (5th ed.). St. Louis: Mosby.

Clark, A. J., Flowers, J., Boots, L., & Shettar, S. (1995). Sleep disturbance in mid-life women. *Journal of Advanced Nursing, 22*(3), 562-568.

Clinical challenges of perimenopause: consensus opinion of The North American Menopause Society (2000). *Menopause: The Journal of the North American Menopause Society, 7*(1), 5-13.

Consensus opinion. A decision tree for the use of estrogen replacement therapy or hormone replacement therapy in postmenopausal women: consensus opinion of the North American Menopause Society (2000*). Menopause: The Journal of the North American Menopause Society, 7*(2), 76-86.

Crawford, M., & Hooper, D. (1973). Menopause, ageing, and family. *Social Science and Medicine, 7*, 469-482.

Crist, J., Armer, J., & Radina, M. (2002). A study in cultural diversity: caregiving for the Old Order Amish elder with Alzheimer's disease. *The Journal of Multicultural Nursing and Health, 8*(3), 78-85.

Dellasega, C., Hupcey, J., & Fisher, K. (1999). Culturalizing health care for a culturally diverse population: The Amish. *Clinical Excellence for Nurse Practitioners, 3*(1), 10-15.

Falk-Rafael, A. (2001). Empowerment as a process of evolving consciousness: A model of empowered caring. *Advances in Nursing Science, 24* (1), 1-16.

Fawcett, J. (2000). The structure of contemporary nursing knowledge. In J. Fawcett (Ed.), *Analysis and Evaluation of Contemporary Nursing Knowledge* (pp. 3-33). Philadelphia: F.A. Davis.

Fawcett, J., & Malinski, V. M. (1999). On the requirements for a metaparadigm: In invitation to dialogue. In J. Kenney (Ed.), *Philosophical and Theoretical Perspectives for Advanced Nursing Practice* (2nd ed., pp. 111-116). Sudbury: Jones and Bartlett.

Freese, B., Beckman, S., Boxley-Harges, S., Bruick-Sorge, C., Harris, S., Hermiz, M., et al. (1998). Betty Neuman Systems Model. In A. Tomey & M Alligood (Eds.), *Nursing Theorists and Their Works* 4th ed., pp. 267-299. St. Louis: Mosby.

Frohlich, K. L., Kuh, D. J., Hardy, R., & Wadsworth, M. E. (2000). Menstrual patterns during the inception of perimenopause: What are the predictors and what do they predict? *Journal of Women's Health and Gender -Based Medicine, 9*(1), 35-42.

Gerdner, L., Tripp-Reimer, T., & Sorofman, B. (2002). Health beliefs and practices: The Iowa Old Order Amish. *The Journal of Multicultural Nursing and Health, 8*(3), 65-71.

Glick, M., Michel, A., Dorn, J., Horwitz, M., Rosenthal, T., & Trevisan, M. (1998). Dietary cardiovascular risk factors and serum cholesterol in an Old Order Mennonite community. *American Journal of Public Health, 88*(8), 1202-1205.

Good, M. & Good, P. (1979). *20 Most Asked Questions about the Amish and Mennonites*. Lancaster: Good Books.

Gullette, M. (2003). What to do when being aged by culture: Hidden narratives from the twentieth-century hormone debacle . *Generations,*71-76.

Halling, S., & Nill, J. (1989). Demystifying psychopathology understanding disturbed persons. In R. Valle & S. Halling (Eds.), *Existential-Phenomenological Perspectives in Psychology* (pp. 179-192). New York: Plenum.

Hautman, M. A. (1996). Changing womanhood: Perimenopause among Filipina-Americans. *Journal of Obstetric Gynecologic and Neonatal Nursing, 25*(8), 667-673.

Hersch, E. (2003). *From Philosophy to Psychotherapy: A Phenomenological Model for Psychology, Psychiatry, and Psychoanalysis.* Toronto: University of Toronto Press.

Hostetler, J. (1980). *Amish Society* (3rd. ed.). Baltimore: The John Hopkins University Press.

Hsueh, W., Mitchell, B., Aburomia, R., Pollin, T., Sakul, H., Gelder, M., et al. (2000). Diabetes in the Old Order Amish. *Diabetes Care, 23*(5), 595-600.

Huffman, S. B., & Myers, J. E. (1999). Counseling women in midlife: an integrative approach to menopause. *Journal of Counseling and Development, 77*, 258-266.

Ihde, D. (1986). *Experimental Phenomenology: An Introduction.* Albany: State University of New York Press.

Im, E., & Meleis, A. I. (2000). Meanings of menopause to Korean immigrant women. *Western Journal of Nursing Research, 22*(1), 84-102.

Jaszmann, L., Van Lith, and Zaat. (1969). The perimenopausal symptoms: the statistical analysis of a survey. *Medical Gynecology and Sociology, 4,* 268-277.

Johannes, C. B., Crawford, S. L., Posner, J. G., & McKinlay, S. M. (1994). Longitudinal patterns and correlates of hormone replacement therapy use in middle-aged women. *American Journal of Epidemiology, 140* (5), 439-452.

Joint Commission on Accreditation of Healthcare Organizations (1994). *1995 Comprehensive Accreditation Manual for Hospitals.* Oakbrook Terrace, Ill: Joint Commission on Accreditation of Healthcare Organizations.

Kittell, L. A., Mansfield, P. K., & Voda, A. (1998). Keeping up appearances: The basic social process of the menopausal transition. *Qualitative Health Research, 8*(5), 618-634.

Kraybill, D. (1989). *The Riddle of Amish Society.* Baltimore: The John Hopkins University Press.

Leininger, M. (1985). Nature, rationale, and importance of qualitative research methods in nursing. In M. Leininger (Ed.), *Research Methods in Nursing* (pp. 1-10). Orlando: Grune & Stratton, Inc.

Lemon, B. (2002). Amish health care beliefs and practices in an obstetrical setting. *The Journal of Multicultural Nursing and Health, 8*(3), 72-77.

Levinson, R., Fuchs, J., Stoddard, R., John, D., & Mullet, M. (1989). Behavioral risk factors in an Amish community. *American Journal of Preventive Medicine, 5,* 150-156.

Li, S., Holm, K., Gulanick, M., Lanuza, D. et al. (2000). Perimenopause and the quality of life. *Clinical Nursing Research, 9*(1), 6-27.

Li, S., Holm, K., Gulanick, M., Lanuza, D., & Penckofer, S. (1999). The relationship between physical activity and perimenopause. *Health Care for Women International, 20*(2), 163-179.

Longworth, J. (2003). Hispanic women's experience with "el Cambio de Vida". *Journal of the American Academy of Nurse Practitioners, 15*(6), 266-275.

Luthy (1997). Amish settlements across America: 1996. *Family Life, 30*, 20-24.

Madjar, I., & Walton, J. (2001). What is problematic about evidence? In J. Morse, J. Swanson, & A. Kuzel (Eds.), *The Nature of Qualitative Evidence* (pp. 28-45). Thousand Oaks: Sage.

Matthews, K. A., Wing, R. R., Kuller, L. H., Meilahn, E. N., & Plantinga, P. (1994). Influence of the perimenopause on cardiovascular risk factors and symptoms of middle-age healthy women. *Archives of Internal Medicine, 154*(20), 2349-2356.

McKinlay, S. M., Brambilla, D. J., & Posner, J. G. (1992). The normal menopause transition. *Maturitas, 14*, 103-115.

McQuaide, S. (1998). Women at midlife. *Social Work, 43*(1) 21-32.

Meleis, A. (1996). Culturally competent scholarship: Substance and rigor. *Advances in Nursing Science, 19*(2), 1-16.

Merleau-Ponty, M. (1962). *Phenomenology of Perception.* London: Routledge Kegan Paul.

Mitchell, E., & Woods, N. (2001). Midlife women's attributions about perceived memory changes: observations from the Seattle midlife women's health study. *Journal of Women's Health and Gender-Based Medicine, 10*(4), 351-362.

Mitchell, E., Woods, N., & Mariella, A. (2000). Three stages of the menopausal transition from the Seattle Midlife Women's Health Study: Toward a more precise definition. *Menopause: The Journal of the North American Menopause Society, 7*(5), 334-349.

Oddens, B. J., Boulet, M. J., Lehert, P., & Visser, A. P. (1992). Has the climacteric been medicalized? A study on the use of medication for climacteric complaints in four countries. *Maturitas, 15*, 171-181.

Palmer, J. R., Rosenberg, L., Wise, L. A., & Horton, N. J., & Adams-Campbell, L. (2003). Onset of natural menopause in African American Women. *American Journal of Public Health, 93*(2), 299-306.

Polit, D., & Beck, C. (2004). *Nursing Research Principles and Methods* (7th ed.). Philadelphia: Lippincott, Williams, and Wilkins.

Polkinghorne, D. (1989). Phenomenological Research Methods. In R. Valle & S. Halling (Eds.), *Existential-Phenomenological Perspectives in Psychology* (pp. 41-60). New York: Plenum Press.

Pollio, H., Henley, T., & Thompson, C. (1997). *The Phenomenology of Everyday Life*. Cambridge, United Kingdom: Cambridge University Press.

Porter, E. (1989). The qualitative-quantitative dualism. *Image: Journal of Nursing Scholarship, 21,* 98-102.

Reiling, D., & Nusbaumer, M. (2002). The Amish drug task force: A natural history approach to the construction of a social problem. *The Journal of Multicultural Nursing and Health, 8*(3), 29-42.

Reschly, S., & Jellison, K. (1993). Production patterns, consumption strategies, and gender relations in Amish and Non-Amish farm households in Lancaster County Pennsylvania, 1935-1936. *Agricultural History, 67*(2), 134-163.

Salmond, S. (2000). Culture learning and unlearning: creating a culture supporting the development of transcultural nurse managers. In M. Kelley & V. Fitzsimons (Eds.), *Understanding Cultural Diversity Culture, Curriculum, and Community in Nursing* (pp. 149-160). Sudbury, Massachusetts: Jones and Bartlett.

Sampselle, C., Harris, V., Harlow, S., & Sowers, M. (2002). Midlife development and menopause in African American and Caucasian women. *Health Care for Women International, 23,* 351-363.

Schott-Baer, D., & Kotal, B. (2000). Frequency and effectiveness of self-care actions and menopause symptoms of middle-aged working women. *MedSurg Nursing, 9*(6), 302-308.

Schwieder, E., & Schwieder, D. (1975). *A Peculiar People: Iowa's Old Order Amish.* Ames: The Iowa State University Press.

Sitelman, F., & Sitelman, R. (2000). Ethics and Culture: from the claim that God is dead, it does not follow that everything is permitted. In M. Kelly & V. Fitzsimons (Eds.), *Understanding Cultural Diversity Culture, Curriculum, and Community in Nursing* (pp. 11-22). Sudbury, Massachusetts: Jones and Bartlett.

Tam, L. W., Stucky, V., Hanson, R. E., & Parry, B. L. (1999). Prevalence of depression in menopause: A pilot study. *Archives of Women's Mental Health,* 2, 175-181.

Thomas, C. (Ed.). (2001). *Taber's Cyclopedic Medical Dictionary* (19 ed.). Philadelphia: F. A. Davis.

Thomas, S., & Pollio, H. (2002). *Listening to Patients A Phenomenological Approach to Nursing Research and Practice.* New York: Springer Publishing Company.

Tiefer, L. (2002). Beyond the medical model of women's sexual problems: a campaign to resist the promotion of 'female sexual dysfunction'. *British Association for Sexual and Relationship Therapy, 17*(2), 127-135.

Tsao, L. (2002). Relieving discomforts: The help-seeking experiences of perimenopausal women in Taiwan. *Journal of Advanced Nursing, 39*(6), 580-588.

Valle, R., King, M. & Halling, S. (1989). An introduction to existential phenomenological thought in psychology. In R. Valle & S Halling (Eds.), *Existential Phenomenological Perspectives in Psychology* (pp. 3-16). New York: Plenum.

Van Hall, E. V., Verdel, M., & Van Der Velden, J. (1994). "Perimenopausal" complaints in women and men: A comparative study. *Journal of Women's Health, 3*, 45-49.

Van Keep, P., & Kellerhals, J. (1974). The impact of sociocultural factors on symptom formation. *Psychotherapy Psychosomatics, 23,* 251-263.

Von Gruenigen, V., Showalter, A., Gil, K., Frasure, H., Hopkins, M., & Jenison, E. (2001). Complementary and alternative medicine use in the Amish. *Complementary Therapies in Medicine,* 232-233.

Wasao, S. & Donnermeyer, J. (1996). An analysis of factors related to parity among the Amish in Northeast Ohio. *Population Studies*, 50, 235-246.

Woods, N. F., Mitchell, E. S., & Adams, C. (2000). Memory functioning among midlife women: Observations from the Seattle midlife women's health study. *Menopause, 7*(4), 257-265.

Woods, N., & Mitchell, E. (1997a). Women's images of midlife: Observations from the Seattle Midlife Women's Health Study. *Health Care for Women International, 18*(5), 439-454.

Woods, N., & Mitchell, E. (1997b). Pathways to depressed mood for midlife women: Observations from the Seattle midlife women's health study. *Research in Nursing and Health, 20,* 119-129.

Writing Group for the Women's Health Initiative Investigators (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: prinicpal results from the Women's Health Initiative randomized controlled trial. *Journal of the American Medical Association, 288*(3), 321-333.

Bibliography

Banks, M., & Benchot, R. (2001). Unique aspects of nursing care for Amish children. *MCN, The American Journal of Maternal/Child Nursing, 26*(4), 192-196.

Beachy, A., Hershberger, E., Davidhizar, R., & Giger, J. (1997). Cultural implications for nursing care of the Amish. *Journal of Cultural Diversity, 4*(4), 118-126.

Berg, J. (2001). Dimensions of sexuality in the perimenopausal transition: A model for practice. *Journal of Obstetric Gynecologic and Neonatal Nursing, 30,* 421-428.

Bing, E. (2002). Lamaze childbirth among the Amish people. *The Journal of Perinatal Education, 11*(2), 13-22.

Brewer, J., & Bonalumi, N. (1995). Health care beliefs and practices among the Pennsylvania Amish. *Journal of Emergency Nursing, 21*(6), 494-497.

Chornesky, A. (1998). Multicultural perspectives on menopause and the climacteric. *Affilia Journal of Women and Social Work, 13*(1), 31-47.

Davidhizar, R. & Brownson, K. (1999). Literacy, cultural diversity, and client education. *The Health Care Manager, 18*(1), 39-47.

Derry, P. (2002). What do we mean by "the biology of menopause"? *Sex Roles: A Journal of Research,* 13-24.

Donnermeyer, J., & Friedrich, L. (2002). Amish society: An overview reconsidered. *The Journal of Multicultural Nursing and Health, 8*(3), 6-14.

Fisher, K. (2002). Lessons learned while conducting research within an Amish community. *The Journal of Multicultural Nursing and Health, 8*(3), 21-28.

Graham, L., & Cates, J. (2002). Health care and sequestered cultures a perspective from the Old Order Amish. *The Journal of Multicultural Nursing and Health, 8*(3), 53-59.

Gregory, T. (1999). Individualized care for the perimenopausal woman. *Patient Care, 33*(4), 47-57.

Greska, L., & Korbin, J. (1997), Influence of changing occupational patterns on the use of commercial health insurance by the Old Order Amish. *The Journal of Multicultural Nursing and Health, 3*(2), 13-18.

Howell, C. (2001). Implications of personal values in women's midlife development. *Counseling and Values, 46*(1), 54-64.

Igou, B. (1999). *The Amish in Their Own Words. Amish Writings from 25 Years of Family Life Magazine.* Scotsdale: Herald Press.

Kraybill, D., & Bowman, C. (2001). *On the Backroad to Heaven.* Baltimore: The John Hopkins University Press.

Kreider, K. (1995). My "plain people" changed the way I practice. *Medical Economics, 72*(19), 131-134.

Lange, C. (2002). Promoting health among perimenopausal women through diet and exercise. *Journal of the American Academy of Nurse Practitioners, 4,* 172-179.

Lindenfeld, E., & Langer, R. (2002). Bleeding patterns of the hormone replacement therapies in the postmenopausal estrogen and progestin interventions trial. *Obstetrics and Gynecology, 100*(5), 853-863.

Lockhart, J., & Resick, L. (1997). Teaching cultural competence: the value of experiential learning and community resources. *Nurse Educator, 22*(3), 27-31.

Marchigiano, G. (1999). Calcium intake in midlife women: One step in preventing osteoporosis. *Orthopaedic Nursing, 18*(5), 11.

Marks, N., & Lambert, J. (1998). Marital status continuity and change among young and midlife adults: Longitudinal effects on psychological well-being. *Journal of Family Issues, 19*(6), 652-687.

McGrath, W. (1998). *Amish Folk Remedies for Plain and Fancy Ailments.* Freeport: Freeport Press.

McQuaide, S. (1998). Discontent at midlife: Issues and considerations in working toward women's well-being. *Families in Society: The Journal of Contemporary Human Services, 79*(5), 532-543.

Reiling, D. (2002). Managing the "marginalized" man: Fieldwork, boundaries, and ethics of involvement. *The Journal of Multicultural Nursing and Health, 8*(3), 15-20.

Showalter, A. (2000). Birthing among the Amish. *International Journal of Childbirth Education, 4,* 10-11.

Speroff, L. (2000). Management of the perimenopausal transition. *Contemporary OB/GYN, 45*(10), 14-25.

Valle, R., & Halling, S. (1989). *Existential Phenomenological Perspectives in Psychology*. New York: Plenum.

Weed, S. (1999). Menopause and beyond. The wise woman way. *Journal of Nurse-Midwifery, 44*(3), 267-279.

Woods, N., & Mitchell, E. (1996). Patterns of depressed mood in midlife women: Observations from the Seattle Midlife Women's Health Study. *Research in Nursing and Health, 19,* 111-123.

Woods, N., & Mitchell, E. (1999). Anticipating menopause: Observations from the Seattle midlife women's health study. *Menopause: The Journal of the American Menopause Society, 6*(2), 167-173.

APPENDICES

APPENDIX A: Institutional Review Board Approval

THE UNIVERSITY OF TENNESSEE

Institutional Review Board
Office of Research
404 Andy Holt Tower
Knoxville, Tennessee 37996-0140
865-974-3466
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07/24/2003

IRB#: 6449 B

TITLE: The Experience of Perimenopause Among Amish Women

Batson, Desiree
Nursing
7226 Blue Springs Rd.
Cleveland, TN 37311

Thomas, Dr. Sandra
Nursing
1200 Volunteer Blvd.
Campus

Your project listed above was reviewed. It qualified for expedited review and has been approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice (Form R) on the anniversary of your approval date.

Sincerely,

Brenda Lawson

Brenda Lawson
Compliances

APPENDIX B: Informed Consent

A RESEARCH STUDY OF THE EXPERIENCE OF PERIMENOPAUSE AMONG AMISH WOMEN

CONSENT FORM

You are invited to take part in a research project. I am doing this study to complete requirements for my PhD degree at the University of Tennessee, Knoxville. The purpose of this research project is to explore the experience of perimenopause among Amish women. Understanding what this experience is for Amish women may assist nurses and other health care providers to more effectively provide care to women, especially Amish women, who are perimenopausal.

The research study will be done through the use of an audiotaped interview that will last approximately one hour (maximum of two hours) in a place of your choice. You will be asked to share your lived experience of being perimenopausal. Further questions will be based on your comments and responses. This interview will be audiotaped so I can use your exact words to understand your experience. The results of the interview will be written out into a printed form for analysis. Your name will not appear on the tape or the written form of the interview and will be known only to me, the principal investigator. Tapes will be transcribed by me. After transcription, the tapes will be shredded. The written form of the interview may be shared with my research group. The written form of the interview will be kept in a locked file in a locked data storage room at my office, which is accessible only to me, the person doing the research. Data without your name will be kept for future analysis. You may contact me, following the interview and during the analysis, to make clear the understanding of your experience. No incentives are offered to you for your time and effort in taking part in the study; however, you may personally benefit by talking about your experience.

The nature and direction of the interview will be determined by you and me and will unfold as the interview develops. You may experience some stress as a result of the interview related to the potential sensitivity of disclosure of your feelings or the emotions the interview may evoke. You are free to choose not to participate in this study or you

can withdraw from this study at any time by notifying me. Your audiotape and/or transcripts would be destroyed upon your request.

Any and all information you provide will be kept in confidence. Neither your name nor any identifying information will be used in any reports although your words may be used to support the interpretation and analysis. At no time will your words be linked or traceable to you.

If you have questions at any time about the study or the procedures, you may contact me at Taylor Circle, Collegedale, TN. 37315, or phone me at (423) 238-2967 or my faculty advisor, Dr. S. Thomas at (865) 974-7581.

I have read the above information and agree to participate in this study. I have received a copy of this form.

Participant's name (print) _____

Participant's signature _____

Date_____

APPENDIX C: Confidentiality Agreement for Research Group

Research Team Member's Pledge of Confidentiality

As a member of this project's research team, I understand that I will be reading transcriptions of confidential interviews. The information in these transcriptions has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information in these transcriptions with anyone except the primary researcher of this project, his/her doctoral chair, or other members of this research team. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

_____ _____

Research Team Member Date

VITA

Desiree Batson was born in Portage, WI on November 14, 1955. She was raised in Portage and graduated from Wisconsin Academy in 1974. In the fall of 1974, she went to Southern Missionary College and received a Bachelor of Science degree in nursing in December of 1977. The Masters of Science degree in nursing was granted by the University of Wisconsin, Madison in May of 1996. She has held numerous nursing positions in the inpatient and outpatient setting. She received her Doctor of Philosophy degree in nursing from the University of Tennessee, Knoxville, in May of 2004. She is currently an associate professor of nursing at Southern Adventist University in Collegedale, TN.